BRINGING 'PRACTICE' TO THE CLINIC:

AN EXCAVATION OF THE EFFECTS OF
HEALTH PROMOTION DISCOURSE
ON NURSING PRACTICE
IN A COMMUNITY HEALTH CLINIC

by

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ABSTRACT

Health promotion is presented in the thesis as a field intruding into current discussions of nursing practice. Following actors into the field of health promotion means recognizing the conventions operating within the field. In particular, conventions operating in the field suggest that talk about health promotion as a practice which could be conducted by nurses, formulated as 'theory', is divided off from the act of health promotion, formulated as 'practice'. Theory is treated as being generated for practice but is understood to come before practice. This effectively institutes a dualism. Theory is understood as required before practice can proceed and practice is treated as following theory. A moral relationship articulates theory and practice in that 'good' practice is treated as being closely representative of prescriptive theories.

Following Foucault's claim that discourse is always practice, the conventional divide between theory about health promotion and practice which is health promoting drops away as a 'fact' complicating representations of practice but is adopted as a strategy for conducting the research project. The ways in which theory and practice are constituted by members as operating in distinction from one another are critically deconstructed. Engaging with research materials from the position that theory and practice are necessarily interlaced, the study seeks to excavate those practices which produce and reproduce the very dualism which is taken by nursing to be self-evident, representing the basis upon which practice is said to proceed.

The study is, in this way, grounded in practice. Attention is focussed on the effects for members as discourse conditions the engagement with and the enactment of nursing. Far from representing an approach to practice which avoids issues of power, health promotion is demonstrated in the thesis to be all too effective at influencing members understandings of their life-worlds in locations quite distant from the conduct of practice. The discourse of health promotion has been silent on the exercise of power. However, the thesis demonstrates how this silence offers a space for members to articulate and network other interests. A particular discourse of health promotion, therefore, does not act as an objective 'gaze', informing members how to 'see' the objects of their practice as widely anticipated in that portion of the literature aimed at developing theory for practice. Instead the discourse of health promotion is demonstrated to have been taken up by members as a facility to break into conversations in order to insert instructions regarding proper conduct.

DECLARATION

I declare that this thesis has been composed by myself and the research reported in it is my own work.

(Mary Ellen Purkis)

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CHAPTER ONE

Introduction

> ... I would like to show that 'discourses', in the form in which they can be heard or read, are not, as one might expect, a mere intersection of things and words: an obscure web of things, and a manifest visible, coloured chain of words ... I would like to show with precise examples that in analysing discourses themselves, one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice. These rules define not the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects ... Of course, discourses are composed of signs; but what they do is more than use these signs to designate things. It is this more that renders them irreducible to the language and to speech. It is this 'more' that we must reveal and describe.
>
> M. Foucault, The Archeology of Knowledge (p. 48-49)

1.0 Introduction: disciplinary orders

Nursing, as a practice-based discipline, reveals order in a visible way. When an observer begins to question the basis of this order the "loosening of the embrace" has already begun. The intrusion of the concept of health promotion acts as a catalyst for the questions. When the question is asked: 'Where does health promotion fit in nursing practice?' other questions soon follow: 'What is the difference between health promotion and nursing?', 'In what ways are they the same?', and 'What is nursing?' Taken-for-granted order is disturbed. A choice becomes evident between falling back to the security of an unquestioned 'order' or moving outwards to slowly and systematically "reveal and describe"

how it is that the signs used to designate nursing come to order the objects making up a practice-based discipline like nursing.

When a 'new' object is imported into an already ordered system an opportunity is created to study how old signs are transformed and new signs created to order and bring the new object into play. It will be argued in this thesis that health promotion offers such an opportunity for nursing. Health promotion is a 'new' object which has clearly intruded into discourses about nursing. This intrusion can be studied to reveal and describe the effects such events have on the ordering which pre-dates the intrusion: events which were, however, only ordered earlier.

1.1 Constructing 'competitive' versions of practice

Literature dealing with health promotion in practice approaches the topic from perspectives which appear irreconcilable. On one hand nursing is presented as a homogeneous practice domain. Turning towards health promotion as a new representation for practice, where the emphasis is on health rather than illness, is treated by some authors as a 'natural progression'. Gentle re-direction of practitioners by self-styled 'enlightened' leaders is claimed by these authors as sufficient to attain the new representation. However, these authors conflate the phenomena of health promotion with claims regarding what is 'new' about nursing in its emphasis on health-oriented practice. That is, health promotion is presented as a new identity for nursing's future. The enactment of this new identity is treated unproblematically.

This 'new', health-oriented version of practice emerges alongside those which characterize nursing as increasingly technical in nature. The literature on health promotion sits well within a much wider debate as an instance of what Giddens has termed "the institutions of modernity" (1991, p. 2). On this view, health promotion is presented as competitive versions of nursing, symptomatic of a particular socio-historical period. Increased specialization, with the concomitant effects of exclusive domains of practice, contributes to a world-view in which advanced, technical practice underlies 'expertise' in practice. Health

and its promotion are treated as discrete practices, definable and available for advancement within distinct domains of expert practice.

1.2 Constituting nursing in language

A study which sets out to examine the place of health promotion in the order of nursing, that is, to reveal and describe that order, must be concerned with questions regarding the nature of order. For instance, questions such as 'Where is this order?' and 'How is it made manifest?' raise themselves for consideration. The position taken in this thesis is that the search for answers to these questions begins, for nursing, in the language of practice.

This can be read as a deliberately provocative position. Nurses often portray themselves or are portrayed in the literature, not as thinkers (where we may imagine that language plays a greater part) but as doers (Melia, 1987; Hagell, 1989; Harbison, 1991; Meerabeau, 1992).

The impetus to study nursing practice in the past has been attributed to facilitating the position of nursing as an academic discipline (Schröck, 1981, 1987; Meleis, 1985; 1990). Claims for positioning nursing within an academic frame are frequently made contingent upon demonstrating nursing as having a strong scientific base (Wilson, 1985; Roy, 1987; Polit & Hungler, 1987). Achieving an 'academic' position for nursing has been treated as a functional manoeuvre so that, as Harbison (1991) claims

> when learners become practitioners they will have an informed basis from which to develop their own skills (p. 407).

Documenting or putting into scientific forms of writing what it is that nurses *do* is advocated by these authors as a necessary first step towards practice which is more informed, perhaps progressive, certainly advanced. However, there is an underlying assumption in much of this literature that language is separate from practice. Practice is studied for the purpose of putting it into language for other uses. In this sense, practice is assumed to be prior to language. Language is characterized by these writers as merely an ancillary device used to point out, to describe, the more important form: practice.

In this thesis, an alternative to accepting the artificial divide between the act of doing nursing and the documentation of that act later, in writing, is offered. Noting from Foucault (1969/1972) that signs do more than designate things, the aim is to examine the language *of* practice. In this sense, language is not to be understood as merely a tool for describing practice (although that itself is a part of the study) but more crucially, language will be taken *as* action. The questions raised are:

> What mechanisms of language are at work which enable nurses to do their practice? and,
>
> How do these mechanisms, and the language of practice emerging from their enactment, affect understandings of what nurses do as practice?

Instead of taking language for granted as a mere tool, useful for translating action into permanent, recordable forms, the position taken in this thesis follows Berger and Luckmann's seminal work on the social construction of reality (1966). Action is only 'thinkable' through language. Language is prior to action, it constitutes action in particular ways and affects understandings of action.

Foucault, writing on the concept of madness, notes the prevailing nature of language on the constitution of objects:

> The unity of discourses on madness would not be based upon the existence of the object 'madness', or the constitution of a single horizon of objectivity; it would be *the interplay of the rules that make possible the appearance of objects* during a given period of time (1969/1972, p. 32-33, emphasis added).

Foucault's aim is to shift attention away from taken-for-granted understandings of madness towards a consideration of how 'knowledge' of madness appears as a discursive unity, to the extent that 'madness' is widely held to be objective and definable in practice. Foucault emphasises the importance of considering the mechanisms by which objects, in the case of this thesis, objects such as nursing or health promotion, are made to appear *as* objects, understood or taken-for-granted as capable of definition in practice.

1.3 Shifting the emphasis for nursing practice

The advent of nursing models in the late 1960's and early 1970's were accompanied by statements regarding new forms of knowledge about and for nurses. Responding to the drive to make nursing academically credible, multiple models and theories of nursing were launched in an attempt to address the perceived need to make nursing a "theory-based" practice (Dickoff & James, 1968; Fawcett, 1984; Meleis, 1985). These models, reflecting the order within which nursing was conceived to exist, in due course, further ordered what came to be 'known' about nursing subsequent to their publication.

An exploration of the discursive unities presently underlying representations of practice, that is, those that make nursing and health promotion appear as objects, can proceed, then, from an examination of accounts of practice as they are currently presented in the literature. For instance, as a relatively new object of concern within the nursing literature, health promotion is presented as a 'change' in the focus of the work that nurses do from that advanced in the models of the 1960's. An example of this is provided by Kelly (1992a) who, reflecting on a definition of health promotion as a process enabling people to increase control over and improve their health, states that

> explicit in this definition is a shift from the traditional methods of health education with specialists providing knowledge to non-expert audiences. Health promotion moves the emphasis from knowledgeable experts to empowered communities (p. 1).

He therefore proposes to explore

> the concept of health promotion ... and the challenges of this concept to nurse education and indeed to the nursing profession as a whole (p. 1).

Health promotion is taken by Kelly as involving a 'shift' in the methods previously relied on to do health education. As an example of a 'discursive unity' underlying representations of health promotion, health education is treated by Kelly as entirely unproblematic. He characterizes it as a pre-cursor to health promotion. The shift advocated by Kelly is not one merely of becoming practised at a different set of skills but implies a more fundamental change.

Health promotion is treated by Kelly as putting nursing in motion. The emphasis is no longer on "specialists" but rather on "empowered communities". Kelly constitutes nursing as a specialist group traditionally involved with informing a "non-expert" audience. Kelly is unable to fully relinquish this representation of nursing when he claims that

> all known societies produce a specialised group of healers of the sick, whose activities are often shrouded in mystery and who develop very special relationships with those for whom they care ... (Kelly, 1992a, p. 4).

Kelly acknowledges the pervasiveness of the 'expertise' of "healers" while at the same time re-inventing the recipients of care as "empowered".

The anticipated change for nursing is, rather interestingly, represented by Kelly in terms of a 'loss' for "knowledgeable experts". The emphasis for educators might no longer be on improving the skills of the experts but rather on facilitating the abilities of the community. Educating nurses to effect change in distant and varied communities, that is to empower these communities, is said by Kelly to be a "challenge" for education and for practice. In contrast to the previously formulated 'scientific' discourse, crucial to the construction of the nurse as specialist, the language used by Kelly to describe practice has shifted dramatically. There is no room in Kelly's construction of practice for 'specialists'. But where does this leave the prior conception of nursing which gains its credibility from an academically sound, scientific base? This problem is not addressed by Kelly.

Setting out to change the focus of work for a group of practitioners who carry out their activities in a wide variety of work settings represents a major undertaking. Further, when practices making up the "traditional" (Kelly, 1992a, p. 1) version of work have not attained a position of secure consensus, tracing such change presents the researcher with very particular methodological concerns.

2.0 'Ordering' knowledge about nursing

Commenting on the production of written material emerging during the period of model development, Flaskerud and Halloran (1980)'s paper entitled

"Areas of Agreement in Nursing Theory Development" has been widely referred to (Kim, 1983; Fawcett, 1984; Meleis, 1985, 1987; Marriner-Tomey, 1989). A debate was expressed between knowledge which is deemed to be unique to nursing and language which is said to be derivative. Pointing to theoretical constructs from sociology, anthropology and psychology as having infiltrated nursing from "outside" (Flaskerud & Halloran, 1980, p. 1), their central point was that "the apparent lack of agreement on what is uniquely nursing" (p. 2), was mere illusion. The "central concepts" (p. 2) which have been identified in nursing were instead said by the authors to enjoy wide agreement within the literature. These "central concepts" were identified as person, environment, health and nursing (Yura & Torres, 1975; Flaskerud & Halloran, 1980, Fawcett, 1984).

The inclusion of 'nursing' as a concept central to the discipline of nursing certainly leaves open the possibility of developing on-going understandings regarding practice. At the same time it signals a deep insecurity about the identity of nursing as a discipline. Nursing as self-referential is insisted on by Flaskerud and Halloran's claim that to be considered a nursing theory, only one of the four concepts need be addressed; however, the one which *must* be addressed is the concept of nursing:

> Nursing theory must include the concept of nursing and, at higher levels of development, must explain and predict how nursing actions affect or interrelate with other concepts to produce a desired patient outcome (Flaskerud & Halloran, 1980, p. 3).

This suggests that the insecurity of what will be considered nursing knowledge can be 'covered' by including the concept of nursing in written form, described as 'nursing theory'. Following from this is the assertion of an obligation for the writer of 'nursing theory' to "explain and predict" the relationship between these actions, now defined as 'nursing', and the intended outcome of these actions. While apparently 'open' to the on-going development of understandings of the nature of practice, the above version of theory implies the possibility of a predictive relation between nursing practice as action and outcomes in terms of the intentionality of those actions.

This thesis stands in contrast to the view taken by Flaskerud and Halloran (1980). As the intrusion of 'health promotion', already referred to, makes clear, nursing is not a concept which enjoys agreement amongst academics or practitioners. A notion of action capable of producing predictable results draws on a discourse of 'scientism'. The four central concepts of nursing identified by Flaskerud and Halloran (1980), offered as the basis for a predictable (but self-referential) science-based discipline, reflect their 'position' in relation to the practice of nursing: a position which takes nursing to be made up of essential elements existing in the form of an objective reality. This position fails to account for nursing as a social process. The position taken in this thesis, in contrast, is that writings such as those of Flaskerud and Halloran reflect concerted discursive attempts to construct nursing *as* a science.

2.1 The place of theory in practice

The development of theory *about* nursing, *for* nursing emerges from an historically prior characterization of nursing as a practical activity, engaged in on a trial-and-error basis. The production of written theories of nursing announced a new version in which practice was described as a systematic activity, based on scientific facts, producing ever-increasing amounts of research-based practice. The discourse is that of 'security' and 'reputability' in clinical knowledge. While reproducing the construction of nursing as previously based in trial and error , it does not 'prove' that such a state existed in some putative reality. An example illustrates the tenuous basis from which claims about nursing knowledge arise. Asking what nursing strategies will be effective in bringing about changes in the knowledge and belief of those receiving nursing care, Schlotfeldt (1987) claims that addressing these questions will:

> produce promising theoretical constructs. They will serve as guides to nursing investigations through which will come advancements in nursing's body of knowledge and improvements in nursing practice (p. 67).

On this view, theory is constituted as representing the outcome of asking specific questions of practice. Amidst the concern to predict outcomes of practice an inversion of the relationship between practice and theory emerges.

A particular view of theory has pervaded nursing thought well beyond the initial development of models in the 1960's. Even a study such as the one undertaken by Lawler (1991), in which she claims to examine the way in which nurses conceptualize the 'body' in practice settings, begins from the premise that nursing lacks a "theoretical space for the body" (p. 8). This 'lack', Lawler claims, makes it problematic for nurses to talk about this aspect of their work. This is to assume, however, that formalized theory is required so that talk and practice, as well as talk *about* practice can proceed. This ignores empirical evidence that nurses already enact body work in their day-to-day actions with patients. In conceptualizing theory as something which comes *after* practice, there is a danger of ignoring the theory which in fact drives practice, theory embedded in practice to such an extent that it is not immediately apparent as 'theory' until the "embrace" between the words and the objects can be loosened.

2.2 Locating theory in practice

Some preliminary excavation of theory embedded in practice has begun with Benner's work investigating the notion of 'expertise' in practice (1983, 1984, 1991) as well as the work conducted with her colleagues regarding the nature and location of 'clinical judgement' (Benner & Tanner, 1987; Benner, Tanner & Chesla, 1992). The direction of this work signals a radical shift in the discourse about practice. Rather than being solely concerned with predicting effective practice, Benner investigates the relationship between language and conceptualizations of practice.

Benner's treatment of action, however, is deeply problematic. First, Benner relies on verbal accounts of practice given by nurses to represent versions of reality. As a methodological problem, these difficulties will be addressed in greater detail in chapter three. Second, she assumes a direct correspondence between the discursive abilities of the nurse and ensuing action. In so doing, Benner neglects the effects of action on the nurse's understanding of practice as well as how action may be constructed by the recipient of 'care': the patient. Relying on what she takes to be a phenomenological perspective, Benner

nevertheless fails to consider the influence of the context of nursing action in both the construction of the nurse's account as well as its meaning in practice.

A contribution to this debate must attend to these problems. There is an obligation to suggest ways of conceiving of action and the actor which not only avoid these problems but crucially, build capabilities, widely treated as 'problems' in the nursing literature (see Meerabeau, 1992), into the theoretical perspective informing the study. In the next section the relationship between theory and practice will be examined in order to shift the debate towards an investigation which treats the action of social actors not merely as problematic but as central to an understanding of how organized practice such as 'health promotion' and 'nursing' are constituted.

3.0 Re-conceptualizing the theory - practice relation

The claim advanced in this thesis is that health promotion is not 'known' in any absolute sense, but rather, is in the process of being produced and reproduced daily through practice, that is, institutionalized. Importantly, this position holds even though that practice is neither systematic nor consensual. This position represents a significant departure from current theorising about nursing which takes a 'unity' of theory as a starting point.

Turning on the distinction arising from Lawler's (1991) work, in which theory was formulated as a necessary pre-condition for talk about practice, the present thesis proceeds from a perspective which takes theory as disciplining talk about practice and the practice itself. On this view, discourse is understood not only as discursive formulations about practice but also the enactment of that practice. In this sense, action speaks often louder than words. The premise is that where health promotion has entered into the discourse of nursing the theoretical space already exists and is implicated in day-to-day encounters between nurses and patients to constitute health promotion. As this thesis will endeavour to show, the theoretical space of such action is there to be revealed and described.

3.1 Elements of a theory of action

Drawing out the link between agency and structure, Giddens' (1976, 1984) theoretical investigations into collective action represents an important synthesis of ideas presently contributing to contemporary social theory. He marks the result of his synthetic efforts with the word 'structuration'. By structuration Giddens means the structuring of social relations across space and time (Giddens, 1984). This signals his intent to situate the hermeneutic project, articulated by Gadamer (1960/1989) and others, into a very particular historical period, that of late modernity.

Giddens asserts that structuration theory offers an explanatory locus for an analysis of social action. By examining a reproduction of practices which 'do the work' of making activities appear 'organized', the dynamic process whereby structures are brought into being through the agency of actors becomes identifiable. Further, with the concept of the duality of structure, Giddens asserts that those structures which are brought into being are not only *constituted* through human agency but are, at the same time, the very *medium* of this constitution. Giddens states his position as follows:

> The constitution of agents and structures are not two independently given sets of phenomena, a dualism, but represent a duality. According to the notion of the duality of structure, the structural properties of social systems are both medium and outcome of the practices they recursively organize (1984, p. 25).

Crucially, Giddens maintains a sense of coherence between agent and structure, giving neither predominance over the other. In this way, he claims to avoid the 'trap' of dualistic thinking which he suggests Parsons' functionalist sociology gave to objectivism and, in contrast, phenomenologists gave to subjectivism (Giddens, 1984, p. xx).

An example from the present study illustrates the process. Observations at a community health clinic demonstrated that a major concern for nurses was screening pre-school children for visual defects. 'Screening' is constituted as a structure through the agency of the nurse, the child and the parent. Prior to giving the child an immunization, the nurse would ask the parent and child to

move to the hall way at the back of the clinic and to stand at a specially marked distance away from the eye chart. The child was asked to cover first one eye and then the other and to read from the chart with the uncovered eye. The child was praised by the nurse for responding correctly to the directions given. The parent was given the 'results' of the screening. During the period of observation no visual defects were discovered using this technique. Movement to a special place, directions to be followed and a result at the completion all serve to constitute the notion of 'screening'. However, at the same time, these actions stand as the medium through which the constitution of these acts *as* 'screening' occurs.

The point to be grasped is that 'screening' can no longer be taken as something fundamental to the work of a community health nurse; it does not exist 'external' to the actors in this situation. Rather it is constituted by agents as they draw on structures within social contexts. At the same time, the action serves to constitute agents as members involved in the act of 'visual screening'.

3.2 Contextualizing practice

An important move made by Giddens is to suggest that structures drawn on by actors within social contexts also facilitate action. Earlier social theorists such as Levi-Strauss and Durkheim, maintained the concern only for structure, seeing rules as constraints on human agency (Giddens, 1984; Douglas, 1975). Giddens' framework maintains the actor's knowledgeability at the centre of this process of constituting reality.

A central problem with the way the theory-practice relation is presently conceptualized in the nursing literature can be illuminated by drawing on the example of the four concepts said to be central to nursing theory. Those engaged in writing nursing theory have been instructed by 'authorities' (Flaskerud & Halloran, 1980; Fawcett, 1984) to organize these nursing texts around the notions of person, environment, health and nursing. These four concepts have been identified and are currently reproduced in the literature as representing aspects of 'interest' to the profession of nursing. The concepts are said to contribute to the identity of nursing. Wildavsky's (1992) investigations into the notion of

'interests' are apposite for he notes that not all interests are "viable" (p. 2). Without a "supporting social context", Wildavsky argues, interests have no "empirical content" (p. 2).

The idea of 'viable interests' is raised to underline a central notion guiding this thesis which is that linguistic structures such as 'nursing' or 'health promotion' do not exist, that is, they are without empirical content, until they are drawn into practice by social actors. Only once this reproduction of structure by empirical agents takes place can an investigation into the constitution of social reality begin. The crucial move I intend to make is that 'nursing' and 'health promotion' are understood in the present thesis as being 'viable' only within a supporting social context, that is, a field of practice defined not only by linguistic structures but by the enactment of structures by knowledgeable agents. A central aim of the study, then, is to explicate how knowledge of what facilitates action is implicated in the viability of interests in practice.

This position has implications for a particular treatment of concepts such as history and power. The perspectives informing the present thesis will be outlined below and developed in later chapters.

3.3 The influence of history on the constitution of practice

According to Gadamer's notion of 'tradition' (1960/1989, p. 280), action cannot be understood outside of space and time. The enactment of health promotion by nurses located in particular places and times, therefore, cannot be separated either from the 'present', or from the past as represented by existing texts written, performed and thus available for the consumption of practitioners located in the present. In this way, practice is said to be 'informed' by the social context of its constitution. At the same time, any enactment of health promotion involves a sense of the future. Implicit in the notion of health promotion at the level of practice is a preparation for an anticipated future for the consumer of the service offered by the nurse. Action in the present holds implications for action in the future as reproducible structures upon which future nursing actions are informed. Action, produced through knowledgeable application of structures available in particular settings is then said to be implicated in the reproduction of

those same structures in future. That is, the duality of structure underlines history as being implicated in the construction of reality.

Giddens' theoretical work is based largely on Berger and Luckmann's (1966) seminal formulations. Berger and Luckmann's concern was to implicate individual actors in the constitution of reality. While Berger and Luckmann's writings suggest connections between structures of signification (those which designate), legitimation (those which explain) and domination (those which facilitate or constrain action) in the construction of situated knowledge, Giddens clarifies this relationship and makes it central to his theory of structuration. In so doing, Giddens acknowledges Habermas' critique of Gadamer's understanding of 'tradition':

> Habermas criticized Gadamer's conception of linguistically saturated 'traditions' for failing to demonstrate that frames of meaning incorporate differentials of power (Giddens, 1984, p. 31).

Gadamer's writings on the "element of tradition in historical research" and the importance of "inquir(ing) into its hermeneutic productivity" (1960/1989, p. 283) represents a central element of Giddens' own theory of structuration. However, what Giddens adds to this position is the influence of power on the constitution of meaning in interactions. As an aspect of central concern, a consideration of the way in which power is conceptualized in the thesis will be expanded upon next.

3.4 Re-orienting the concept of power

In any interaction between agents there is always the production of meaning. This is widely accepted. However, as Foucault (1969/1972, p. 49) notes, signs do more than designate. What Giddens attempts to underline, in recognition of Foucault's influential writings, is that the production of meaning is only one element of interaction. Every interaction is also a moral and a power relation.

Giddens' writings on structuration theory have been accompanied by a body of criticism regarding his central claims (Willmott, 1986; Holmwood & Stewart, 1991; Bryant &Jary, 1991; Munro, 1991a; Craib, 1992). Of particular

importance for the position informing this thesis is that Giddens claims, but never clearly demonstrates, that the elements of domination, signification and legitimation are only analytically separable. Current theorising on power suggests how the interlacing of these structures underpins action (Munro, 1991a).

What Foucault calls the "more" (1969/1972, p. 49) implicated in the ordering of objects is important. As noted earlier, actions engaged in in practice-based disciplines such as nursing are neither systematic nor consensual. Rather, each encounter is different, readings of social context enable some actions while at the same time constraining others. While intuitively acknowledged, the conditions underpinning such a perspective on practice are largely absent within the nursing literature. A theory of action which claims to examine practice must be capable of taking such matters into account.

Current theorising on power offer interesting possibilities. For instance, Lyotard's (1979/1984) development of Wittgenstein's analogy of the "language game" retains the notion that

> no one, not even the least privileged among us, is ever entirely powerless over the messages that traverse and position him ... (Lyotard, 1979/1984, p. 15).

This version of power is more fluid and relational than that typically advanced in the literature which takes power as hierarchical. Nurses have been characterized as negotiating 'in between' the more powerful physician and the patient (Benner & Tanner, 1987). The patient is characterized in much of this literature as being in 'need' of an advocate (for instance see, Morse, 1991a). Such representations of nursing can be critically examined in light of Lyotard's writings where each individual participating in interaction with others is understood to have the potential to "displace" others in interaction (Lyotard, 1979/1984, p. 16). The effects of health promotion having entered the discourse of nursing can be re-conceived as having implications for individuals engaged in encounters organized as 'nursing care'.

Also in this regard, Latour's (1986, 1987) work on the exercise of power as "translation" points to a perspective on institutionalized action which allows for an analysis of action as non-consensual. Rather than reifying power as

something hoarded, stored up and used at particular moments, Latour turns presently accepted conceptualizations of power around by pointing to the potential of examining how, through the "exercise of power", power can be treated as an "effect rather than as a cause" of action (1986, p. 266). Thus, when examining interaction, members of the encounter are said to be "enrolled". While action may appear 'collective' and similar, this only masks differences in the translation picked up by individual actors. For Latour, it is a "faithful transmission of order" (1986, p. 267) which requires explanation as a rarity rather than the rule. Individual members of the encounter are taken as not simply resisting the power of a more dominant other, a position which Giddens frequently falls victim to (Holmwood & Stewart, 1991, Munro, 1991a), but rather are said to be actively constituting their enrolment in the interaction thus contributing to the existence and maintenance of order amongst members.

3.5 The active constitution of health promotion in practice

It is precisely such a perspective, one which facilitates a critical analysis of action, permitting an investigation into representations of collective action which is called for in the present debate about the place of health promotion in nursing practice. Arguing positions for or against the advisability of engaging in health promotion (Beattie, 1990; Luker & Caress, 1989; Wright & Levac, 1992) or in constructing a definition of health promotion based on discursive accounts of practice as idealized versions of practice (Smith, 1981; Denny & Jacob, 1990; Latter et al., 1992; Kelly, 1992b) lead inexorably towards merely expanding the repertoire available for the construction of accounts of practice. What these positions fail to do is to contextualize accounts by looking towards the field of practice in order to reveal and describe the way in which structures are drawn on by knowledgeable actors to shift understandings whether *of* practice or *in* practice. This motility of understandings becomes the focus for the present thesis which is thus concerned perhaps most centrally with an exploration of the ways in which knowledge is implicated in the exercise of power.

The thesis aims at contributing to a debate on the nature of practice historically situated in late modernity (Giddens, 1984, 1991). That is, practice is

understood in this thesis to be conditioned by "institutional dimensions of modernity" (Giddens, 1990, p. 59) such as surveillance, power, transformations of nature and arrangements governing the production and consumption of health care. The goal is to reveal how these conditions affect the particular ways in which health promotion is constituted and enacted in practice settings by excavating discursive formations from which versions of 'practice' emerge.

4.0 Summary of a framework for investigating social action

Health promotion has been introduced in this chapter as a field which has had particular associations drawn between it and its relations with the practice-based discipline of nursing. The major premises underlying the proposed study of the field arise from competitive versions of practice comprising the literature on health promotion. It has been argued that the phenomena of health promotion as action has been conflated with claims for advancing a new identity for nursing. This has resulted in widely variable claims regarding the potential of health promotion in nursing practice. Attempts to de-centre the power of professional expertise largely ignore competing versions of practice formulated within a discourse of increasing technicalization of that practice.

Complicating representations of practice are notions regarding the relation between theory and practice currently expounded in the nursing literature. In particular, nursing has demonstrated a concern to represent practice as though it arises from a 'unity of theory' [see page 10 above]. Rejecting the version of 'theory' as unified and detached from practice, the thesis proceeds through an examination of practices which, crucially, are understood as neither systematic nor consensual. Giddens' structuration theory was introduced as offering an analytic position from which the conduct of nursing understood as non-consensual action can be studied. Importantly, structuration theory does not rely on the dualism between theory and practice conventionally applied in the

nursing literature where theory is treated as though it is detached from practice. Giddens' move to redress dualisms such as this one found widely in the nursing literature is anticipated by Foucault's recognition that discourse is always practice. Discursive strategies employed within the nursing literature to incorporate health promotion into the discipline of nursing can, on this view, serve as practices to be studied in their own right as contributing to present understandings of the place of health promotion within the discipline of nursing. While perhaps not fully capable of addressing the problems established in this introductory chapter, structuration theory does offer an explanatory locus for addressing the concept of power as it is implicated in the constitution of knowledge in practice.

In the next chapter the literature on health promotion is critically reviewed. The review is guided by a concern to excavate discursive structures ordering representations of health promotion. That is, I will explore the ways in which practice, as action, is represented. Within the framework adopted for this study, the review aims not only at excavating what is included in conceptualizations of health promotion and practice but also, and perhaps more importantly, what is excluded. The aim is to excavate how 'theories' of health promotion are attached to 'practice' and to clearly demonstrate how such attachment takes place largely through the 'silent' detachment of theory from practice, that is, by ignoring the theory that drives practice [see page 9 above].

Issues raised in this introductory chapter regarding the treatment of theory as a disciplining order are extended as methodological concerns in chapters three and four. Currently held conceptualizations of action are examined in terms of the effects they have on understanding practice as an activity which can be treated, as it is in this thesis, as actions engaged in by all members contributing to the field: nurses, clients, researchers, educators. The aim then, is to problematize 'practice' as it has come to be constituted as a 'site'

for study. By giving critical attention to the literature in which conventional frames for understanding health promotion are applied, a 'site' for the present study is cleared. The thesis stands as an example of a critical study of practice, one in which members engaged *in* practice as well as their actions *as* practice become accessible in particular ways and by particular means for research.

The theoretical position developed in the early chapters is eventually turned in upon itself, now representing a horizon of new understandings regarding practice. The 'field' of practice, now understood as fully interpenetrated by theory, is investigated to reveal and describe particular ways in which understandings of practice are accomplished. Understandings are excavated through critical readings of a particular example: the conduct of practice in a community health clinic.

Critical readings of practice are, it will be reiterated, not undertaken so that the outcomes of practice can be predicted. Instead, the provocative move of throwing the central orders of the discipline into question is taken in order to address those questions which have been lost or long-ago silenced in the discipline's drive for academic credibility. Questions addressed in this thesis, attending to an entirely different discursive space from that of prediction, are aimed at understanding. Thus, the thesis moves on now to "reveal and describe" where and how health promotion 'fits' in nursing practice.

CHAPTER TWO

The Detachment of Theory from Practice

in Studies of Nursing

> Public health workers often meet with undesirable mental attitudes in the population on questions relative to public health. For example, one might mention the opposition to milk pasteurization, the antagonism to quarantine regulations, the practice of self-diagnosis and self-medication, the confidence in bone-setters and quacks ... Naturally, these attitudes are a result of insufficient knowledge, and are usually associated with improper living practices ... We must put a stop to this waste of life and money. Such a mentality is the result mainly of defective education, and better health teaching would contribute in no small measure to change the situation for the better ...
>
> J. Gilbert, Health teaching in the primary school (1942)

1.0 Introduction: a constructionist perspective on health promotion

Drawing the arguments introduced in the previous chapter forward, the aim is to illuminate the ways in which knowledge about health promotion in the literature is presently ordered. The central point brought forward from Giddens' framework (1984) is that, through language, we organize and understand ourselves in the world. Language and self are inextricably linked, constantly in motion within the hermeneutic circle of understanding and self-constitution. Within the framework of structuration theory individuals are taken to be knowledgeable actors, drawing on 'knowledge' as it arises through this hermeneutic, self-constituting effort: thus the importance of clarifying the present state of 'knowledge' as it is organized into written form.

1.1 Influences on the practice relationship

With this in mind, two aspects of the study can be accomplished with a review of the literature. First, raising the question regarding how the relationship between nurse and patient is presently constituted in the literature, the influence of the "central concepts" (Fawcett, 1984) of person, environment, health and nursing offer a background against which the relationship can be critically explored. The goal is to ascertain what effect the central concepts may have on orders of knowledge regarding the setting up of health promoting events in practice.

Secondly, a central question informing this review is how the nurse is constituted within the literature to enact health promotion. Competitive views regarding the position of the nurse in relation to the patient raised in the introductory chapter will be explored further in this chapter. The aim is to tease out instances where health promotion as a 'new identity' for nursing has been combined, perhaps covertly, with discussions of health promotion as a phenomenon enacted within a particular form of practice relationship.

The review seeks to unearth presuppositions underlying prescriptions for practice and descriptions of that practice. The aim is to clarify the conditions upon which such prescriptions rest: the conditions of practice. Clearly practice does not happen haphazardly; much preparation goes into making it happen, and, making it happen in particular ways. These ways are accomplished by actors emphasizing certain actions and excluding others. What is written about nursing cannot be divorced from how nursing is practiced.

Within this thesis, what is written about nursing is understood as one of several forms of accounting for the practice of nursing. Other alternative forms for generating accounts of practice may be obtained through observing practice and verbal accounts given by nurses and patients of practice. These forms will be explored as methodological issues in chapters three and four and as empirical issues in chapters six through ten.

To restate the perspective taken in this thesis: what is included in the account as well as what is excluded from it and how accounts are accomplished by

actors understood to be knowledgeable, represent the materials upon which the constitution of practice will be revealed.

1.2 Constituting the 'practice relationship'

Health promotion, as a set of practices claimed by nurses to represent at least part of their daily work, offers an excellent opportunity to study the ways in which nurses draw on available structural resources and apply them in new ways to constitute certain nursing actions as 'health promotion'. Nurses who are actively entering into health promoting situations are literally creating theory as they practice. Crucially, the health promotion event takes place within the practice relationship. So how is this relationship characterized in the literature?

Perhaps the most widely drawn on approach is that which characterizes the practice relationship as one involved with prescribing actions identified by the author as those fulfilling the obligation for 'good' nurses to consider the client's health as well as symptoms of illness. This prescriptive literature makes up a majority of literature on the topic of health promotion (for a recent review, see Latter et al., 1992). Advice is provided for practicing nurses within a frame which takes prior practice to be merely faulty. For instance, Wright and Levac (1992) advise that,

> it would be more respectful and more humble for us to think of ourselves in non-hierarchical, collaborative relationships with families; that we are involved in co-drifting with families creating a context for change rather than believing we can be change agents (p. 916).

These authors recognize by default the present situation in which the practice relationship is described as hierarchical, suggestive of the influence of power differentials. However, rather than addressing how this factor contributes to the relationship, they merely recommend side-stepping power.

Distinct from the prescriptive literature is the highly technical program of research initiated by Nola Pender (1982, 1987). There are few formalized theories or models of health promotion available for consumption by practitioners of nursing but Pender's model of health promotion represents one notable exception. Pender's model of health promotion attained a high profile in the

mid-1980's. The extent to which this model is referenced in works on the topic of health promotion lessened towards the end of the decade but shows evidence of re-appearing again (Pender, 1990; Viverais-Dresler & Richardson, 1991, Troumbley & Lenz, 1992).

These two broad categories of the literature will be reviewed in greater detail in the following sections. The aim is to interrogate the literature with regard to the practice relationship underpinning each. The formulation of person, environment, health and nursing will remain in the background. It is quickly apparent in reviewing this portion of the literature that these constructs are frequently taken-for-granted and, with the result identified by Wildavsky (1992), they lose their empirical meaning. This, it was argued in the previous chapter, was the outcome of failing to contextualize constructs within the social constitution of the reality they describe. Thus, in the following sections the aim is to understand the underlying reasons for such a failure to contextualize the central concepts in writings which deal with the practice relationship.

2.0 From education to promotion: colonizing a site for practice

The evident paternalism inherent in Gilbert's (1942) expectations for "better health teaching", an excerpt of which appears in the epigraph to this chapter, has been effaced in much of the contemporary writing on 'health education' and 'health promotion'. In this chapter I want to explore the mechanisms used by authors to accomplish this effect.

The identification of health promotion as a set of activities which are taken as qualitatively different from health education is a distinction only recently emerging in the nursing literature. The two terms continue to be frequently interchanged for one another. When authors do make a distinction, health promotion assumes a superior position to health education. In the following example, the author describes the expected contribution of health visitors in the United Kingdom as they "move towards" health promotion:

> If health education and health promotion are viewed as being two points along a continuum then present health visiting practice is currently at the health education end. In order to affect the health of the whole community and not just those

> amenable to health education campaigns it is necessary to move towards health promotion while still retaining health education strategies as part of an overall approach. (Denny & Jacob, 1990, p. 8)

Similar to the strategy used by Kelly (1992a), health promotion is characterized as a shift away from individual interventions toward an approach which would take in the "whole community". Health promotion is represented as being an 'advanced' version of health education, the distinguishing feature being its extension beyond individual care to "community" care.

Duffy (1988) also draws on an extension away from the individual to collective action to re-orient the nurse's work towards health promotion. This move is legitimated by taking recourse to suspect statistical claims. In the following example Duffy (1988) claims that

> the family assumes responsibility for at least 75% of all health care provided to its members (p. 109).

Therefore, Duffy claims, nursing research should focus on

> the interaction between family dynamics and the prevention and treatment of diseases (p. 109).

The effect is not only to extend the nurse's legitimate influence into the community where Duffy's families are said to reside, but also to claim the family as valid territory for nursing research.

Moves to make the family the object of nursing work are widespread in the literature. Frequently such moves are accompanied by banner slogans such as the family representing an

> area in which nurses are able to practice independently (Tansey & Lentz, 1988, p. 178),

and that an assessment of "family functioning" can be applied to

> specific case management issues or problems that arise (deChesnay, 1986, p. 96).

Two specific goals of practice are addressed through consideration of the place of the family in nursing work. One, clearly situating nursing's new identity, is that the family offers a site for the nurse to practice independent of traditional constraints attributed to the medical model of individual care. Secondly, pointing towards the phenomenon of enacting health promotion in practice, that by extending their territory into the family arena information gained there can be

brought back to the individual to solve "problems that arise". Such a vague goal for practice reflects the lack of consensus regarding what health promotion would look like *in* practice.

2.1 Constituting positions within the relationship

These two goals are not unrelated. They represent a structurated process in that the family has been constituted as both medium and outcome of the practice relationship. That is, by first constituting 'family' in particular ways and then re-defining the importance of the family as the location of knowledge to be harnessed by the nurse in order to enact individual care (the medium), the family (as outcome) comes to represent a construct of particular importance in legitimating autonomous practice for nurses (Anderson & Tomlinson, 1992; Wright & Leahey, 1984, 1987; Friedman, 1986). On this reading, the 'new' category of 'family nursing' emerges as the outcome of constitutive work involving understandings of nurse, patient and care. Having been constituted in this particular way, the status of 'family' now *requires* corroboration by nurses working in the community.

Pointing to statistics, treated as 'facts', which suggest that significant amounts of health care take place in the home setting, Duffy (1988) claims that nursing research must exert its legitimate right to study health where it occurs: in the family home. Having created the family as an object of concern, Duffy invests the family home with legitimacy, equal to that of other health care establishments. Citing American national nursing associations and the World Health Organization, Duffy underlines her claim that "the family is a client of nursing" (1988, p. 109) with the 'ratification' or 'endorsement' of professional organizations. Amid the rhetoric of 'service provision', the relationship between nurse and family is displaced so that the family is constructed as 'available' to the nurse, not the other way around.

The examples of texts written about nursing demonstrate how 'new' links legitimating the nurse's position with regard to the object of nursing action underpin claims about promoting health as an activity. Making claims that the nurse should address the needs of families in the practice of health promotion,

Duffy demonstrates how easily her version of nursing colonizes the family group, taking on the instructive role, in order to inform them about health. Drawing metaphorically on notions of 'mapping out new territory', the nature of the practice relationship is drastically altered. Claims to professional autonomy clash with egalitarian notions of de-medicalization of care, resulting in an ambiguous description of nursing practice.

While clearly pointing to the exercise of power in their moves to position themselves, the recipients of their service and therefore the service they provide, power is never directly addressed. Instead it is displaced in a variety of ways. In the following sections the ways in which power is displaced through discursive structures such as 'expertise' and 'technology' are explored.

2.2 Nurse-as-expert

Generally, the nurse is characterized as being a knowledgeable expert and the client, whether conceived of as individual, family or community are characterized as being passive recipients of this knowledge. The 'nurse-as-expert' theme is a common one in the literature. An example is provided by a study carried out by Francis, Roche, Mant, Jones and Fullard (1989). Fifty-three general practitioners and sixty-one nurses in England were given a case history of a middle aged man with high blood cholesterol levels. The study participants were asked to indicate the three "most important questions" (p. 1620) they would ask this hypothetical client and the six "most important pieces of advice" (p. 1620) they would give him to modify his diet.

The responses given by the participants were then evaluated in light of the recommendations set out by the National Advisory Committee on Nutrition Education and the Committee on Medical Aspects of Food Policy. The researchers noted "deficits" (p. 1622) in the ability of the participants to offer "practical and appropriate" (p. 1622) advice in response to the case study material provided. When compared to the 'ideal' role of knowledgeable expert which authors such as Duffy (1988) claim nurses can fulfil, these results provide sobering evidence of the limitations on this 'knowledge'.

More importantly however, the research stands as an instance of how the authors constitute health care professionals as experts. The development of tools and research projects which set out to "test" the extent of nutritional knowledge and application of that knowledge in a hypothetical case are in fact testing the same resources which are produced by health professionals. The research project 'anticipates' a certain availability of facts with which health professionals approach clients. The 'negative' outcome of the survey re-produces the expectation that health professionals should 'know' about dietary guide-lines.

> The results of this survey do not give cause for complacency. Clearly, improved nutritional education and training in dietary counselling of all primary health care workers are urgently needed (Francis, et al., 1989, p. 1622).

Such prescriptions rest on highly simplistic notions of structure and agency. "Nutritional education" is implied as a value-neutral structural entity applied in practice through the agency of the health care worker. The worker is characterized as in need of preparation for this job, labelled "counselling". But the structure of education is treated as wholly separate from the agency of the individual worker.

Giddens' conceptualization of action takes these aspects not as separable entities linked in a mechanical way through the person of the 'counsellor' but rather, that "counselling" represents a social accomplishment involving the active construction of the practice relationship by agents drawing on structural aspects to produce meaning within that encounter. Rather than privileging the worker's part in the production of meaning, Giddens' framework reminds us that all members influence the constitution of the encounter as a social event. That is, the construction of the encounter as 'counselling' must also account for the 'patient's' part in this construction. Emphasis on the professional's position as that of 'expert' displaces consideration of the effects of the practice relationship on the service recipient. The authors of this study demonstrate an unwillingness to consider their construction of the work studied as possibly irrelevant within the life-world of the workers and recipients of the service. Re-training of professional actors is commonly suggested when professional interventions are discovered by researchers to have been 'ineffective'. Such attention often goes

hand-in-hand with a discourse of 'specialization' (Ellis, 1982; Vojtecky, 1988; Downs, 1988; Bramadat & Chalmers, 1989; Beattie, 1990).

Remedial action in the form of 'improving' communication skills to enhance the effective transfer of information reflects a response to conditions operating in "core geographical areas of modernity" (Giddens, 1991, p. 30). With the lay public no longer conceived of as capable of surviving on 'local knowledge', specialists constitute a platform from which they emerge to provide 'expert knowledge' to assist in day-to-day functioning. "Disengagement" (Giddens, 1991, p. 30) from expertise is no longer possible, thus constituting the 'counselling' encounter as one which is inherently powerful. Simplistic treatment of such encounters takes no account of the structural organization of the encounter affecting and influencing information transfer.

2.3 Accounting for the service recipient

An alternative view on the advantages of 'retraining' is offered by Molzahn and Northcott (1989). They argue that due to the greater availability of health information to the public at large, researchers have assumed a greater convergence between the perceptions of patients and health care providers regarding the concept of health. Their review of the literature suggests that this assumption is not valid and, importantly, that convergence of perceptions about health do not increase "once the patient education process has been completed" (p. 138). Within the framework offered by structuration theory, 'retraining' programmes can be seen as mechanisms which reproduce structures health professionals already draw on to legitimate their position of expertise over the client. This effect can account, in part at least, for the difference in "perception" noted by Molzahn and Northcott (1989). Rather than moving closer to the perception of health held by the recipient of health promoting services, they argue that re-training has the effect of further solidifying professionalized versions of health.

Brehaut's descriptive study (1988) of the development of health promotion programs provides evidence of this effect. As part of a 'clinical experience' for their program of study, students from the nursing department

conducted a survey of all faculties and departments at a Canadian university with the aim of determining areas of "health interest" (p. 20) among students, staff and faculty members. Responding to an identified "health interest" in stress, the nursing students implemented a series of "regular meetings" (p. 21) where discussion of strategies for coping with stress arising from the student experience were conducted. The nursing students

> adapted a stress assessment questionnaire and administered it to the experimental groups before and after the series of meetings and to control groups at the same times (Brehaut, 1988, p 21).

The questionnaire was claimed by Brehaut to play a part in determining the effectiveness of the nursing students' 'intervention'. The decision to evaluate the program in this way reflects a naive assumption that interventions made by the nursing students represent the sole intervening factor altering the perceptions of the participants. The use of an 'experimental design' to test the effectiveness of the strategy attends to a discourse which legitimates the exercise as being scientifically sound rather than evaluating the program.

With an aim similar to that of Brehaut's descriptive study, the 'Heartbeat Wales' campaign, studied by Davison, Davey Smith and Frankel (1991) was designed to increase awareness in the population at large of the dangers of heart disease. The aim of the 'Heartbeat Wales' project was to have individual communities develop local programs in order to develop local solutions to improve heart health. Pushing the choice of solutions to professionally-defined health problems down to the local level aligns with an underlying premise of the social policy approach to health promotion. Within this perspective, healthy choices are those which are determined locally as easy choices for the public to make (Milio, 1986; Innes & Ciliska, 1985; Innes, 1987; Davison et al., 1991).

The aim of the research project conducted by Davison and his colleagues was to explore the extent to which scientific theorizing about heart disease, as transmitted in the discourse of the Heartbeat Wales campaign, had penetrated into lay discourse and what effect this may have had on lay understandings about heart disease. The researchers conducted semi-structured interviews with 180 adult respondents from both urban and rural districts in the area where the

Heartbeat Wales campaign had been in effect. They also undertook informal observation and discussion with adults from across social classes over an 18 month period.

Their findings demonstrate what they term the "prevention paradox" (Davison, et al., 1991, p. 15). The effect of the "cultural engineering approach" (p. 16) taken by the Heartbeat Wales campaign is that the perception in the lay population of the number of people who are 'at risk' of heart disease increases greatly.

> People who ... never thought of themselves as being at risk (from their diet, for example) now do (p. 16).

This has, according to the authors, the paradoxical effect of creating the perception within the lay population that a greater number of individuals who have been defined as being 'at risk' actually survive their risky behaviour.

A second effect noted by these researchers is that the correspondingly small number of individuals who, despite not being located in the 'at risk' category, but who still fall victim to heart disease gain a heightened public profile because their 'victimization' is unexpected. The surprise of learning that a 37 year old athlete has suffered a massive heart attack is frequently the cause of considerable media attention -- specifically because this event is 'unexpected'. As an instance of 'constructed order', that illness can be prevented through risk identification, an order perpetuated by a campaign such as Heartbeat Wales, unexpected events take on greater significance because they initially contradict the constructed order.

An unexpected instance of heart disease becomes worthy of remark within lay discourse about health precisely because it does not fit into the expected order of things. The researchers discovered that the campaign provided the lay public with a discourse with which they could attribute symptoms they may have experienced themselves or to be able to identify friends or relatives who are 'at risk' of heart disease. In the event of a friend or relative having to enter hospital because of 'heart problems' the respondents were able to develop an explanation "which can account for the occurrence of the misfortune" (Davison et al., 1991, p. 1).

The significance of this study for the present thesis lies in recognizing that the discourse of health promotion is drawn on by members of communities as a system for the production of accounts (Giddens, 1984; Roberts, 1991). The study demonstrates the consequences which such unexpected, mysterious events as a sudden death from heart attack have in a community and the attending 'folklore' which develops as a result of such occurrences. Davison and his colleagues have presented a description of practice rarely found within the health promotion literature: the language of practice has been accounted for as it effects the constitution of understandings about health. In contrast to studies identifying 'gaps' in a repository of knowledge (as the health professional is characterized) to be solved by remedial training, Davison's study points to the generative function of language in constituting meaning in encounters. However, lacking a robust theory of accounts, the authors are unable to demonstrate how the generative function of language in fact enables members to move and position themselves by drawing on such accounting systems.

Lyotard's (1979/1984) work on language games would extend the analysis. Rather than treating the lay public as merely more clever than the experts would give them credit for, each member of the language game is understood as capable of being positioned or positioning others with 'novel moves' in a language game. Accounts given by members involved in the language game would then serve to illuminate, not only the nature of the game, but also how moves were made to accomplish specific positions in relation to one another.

2.4 Influences of power: displacing power through technology

One way of accounting for divergent views of health promotion in the literature is by critically examining how 'knowledge' is treated in this literature. Davison and his colleagues clearly take a constructionist stance whereby concepts such as 'health' are influenced by media campaigns. Their study suggests that such influence cannot merely be attributed to a particular pamphlet having been distributed within a geographical area. Rather, the meaning of the message may be influenced by personally held beliefs and understandings about health. Their study introduces a notion of relativity into the communication process.

The implication of their study is that the effects of a health promotion campaign cannot be fully anticipated and therefore attempts to guarantee or maximize effectiveness are misguided. This raises a central dilemma apparent in the health promotion literature.

On one hand, health professionals or health campaigners are characterized as the repositories of 'special knowledge' which they can apply in practice situations to improve the health of the population, whether that be an individual or a nation. On the other hand, an underlying distinction between health promotion and traditional health care rests on a shift away from prescriptions for better health as dictated by professionals, towards the lay population deciding for themselves how their health can best be promoted (World Health Organization, 1986; Kickbusch, 1981, 1989; Milio, 1986, 1990; Minkler, 1989; Bryant, 1988).

Rarely acknowledging the influence of power differentials in the practice relationship, the nursing literature is replete with prescriptions for managing the interpersonal relationship (see Macleod Clark, 1982 and May, 1990 for extensive reviews of this literature). The importance of constructing a relationship between the nurse and client whereby the nurse seeks some form of involvement with the client has been explored by May (1991). Involvement is most often claimed to be accomplished by means of advanced communication skills. Appropriateness of social contact and interaction are identified as the goal of skilled communication and are said to assist the nurse in undertaking

> assessment, giving information and advice, as well as an opportunity for discussion and expression of feelings (Macleod Clark, Hopper & Jesson, 1991, p. 41).

Communication is treated unproblematically in the literature, placing an obligation on the nurse to enter into contrived encounters with clients in order to achieve the sense of 'involvement' implied. May (1991) has drawn attention to the fact that the obligation on the client to express their feelings as a result of the nurse's approach is rarely addressed within such prescriptions for practice.

A practical objection is raised to the emphasis in the patient teaching and advanced communication literature by Luker and Caress (1989). Following an all too infrequent critical review of literature on patient education, these authors

point out that much of the literature has linked the concepts of 'teaching' with 'compliance'. Rather than enlightening patients through the provision of information, these authors suggest that education is being used as a mechanism to control patient behaviour.

Their review of the literature reflects the findings reported earlier in this chapter by Molzahn and Northcott (1989) in that teaching done by the nurse does not necessarily improve the disposition of the client to carry out or maintain long-term health behaviour change. Luker and Caress (1989) claim that current nurse education practice in the UK is insufficient to prepare qualified nurses to address the learning needs of a primarily sick adult population. They suggest that computer-assisted learning be examined as an alternative to relying on the nurse for the provision of information required by clients. Having earlier identified the influence of power in the relationship between the nurse and client as a reason why patient education had become transformed into a mechanism to achieve compliance, Luker and Caress suggest that the way to alleviate this 'problem' is to remove the educational experience from the person of the nurse and instead, invest it in the technology of the computer.

By suggesting the 'move' to the computer as the location of information these authors assume that the nurse's authority will be mitigated because the patient does not have to rely on the nurse's presence for teaching to take place. This surely is a naive understanding of the notion of power and presence.

While the person of the nurse may be absent at the time the patient uses the computer program, the order of knowledge invested into the program is merely 'hidden' by technology. Luker and Caress' (1989) naive embrace of such distanciated technologies as computer packages for patient education neglects the extent to which the information transmitted by the computer affects the patient as an extension of the ordered knowledge formerly transmitted in a more direct manner through professional encounters. In terms of the direction taken in the present thesis it is important to note the major debate on the topic of technical transfer of knowledge taking place in the wider sociological literature.

Callon (1986), Law (1986) and Latour (1981, 1986, 1987) are theorizing the effects of technology on what they described as 'action at a distance'. Latour (1986)

notes that his understanding of power as an effect is derived from Foucault's writings on disciplinary technologies (1975/1977). Latour regards his own work as "an expansion of Foucault's notion to the many techniques employed in machines and the hard sciences" (Latour, 1986, p. 279). Increasingly technical environments for the practice of nursing represent fields which still await research.

2.5 Influences of power: erecting boundaries around promotion

As an alternative means of displacing the issue of power, those advocating a de-professionalized posture towards health promotion demonstrate an attention to the redistribution of boundaries between those designated to promote health and those whose health is to be promoted. Approaching health promotion from the perspective that underlying social conditions are primarily responsible for illness, those advocating the development of social policy to address health promotion, position themselves by distinguishing their approach from those whom they characterize as 'traditional' and 'medically oriented'.

Stachenko (1992) offers an historical overview of the development of health promotion ideologies in North America, noting as Minkler (1989) did, that the emphasis in the United States has been on "stressing mainly individual lifestyle modification" (p. 5). Citing cultural differences between Americans and Canadians, Stachenko suggests that development of health promotion programs in Canada has followed more closely the line developed by the liberal democratic model of the World Health Organization's (WHO) European Regional Office in Copenhagen.

Stachenko notes that one of the major differences between an individual responsibility position and that advocated by the World Health Organization is in the

> recognition that people's health is determined by factors lying beyond their individual control (and sometimes originating completely outside the health care sector) (Stachenko, 1992, p. 5).

The 'health policy' approach advocated by the WHO effectively severs the traditionally exclusive relationship between 'health' and 'health care professionals'.

While raising the issue of professional dominance as highly influential in the constitution of health promoting activities, the effect of such an oppositional arrangement displaces the boundary towards other, less traditional authorities. For instance, professional engineers (Small, 1989) now are treated as having a 'legitimate' place for commenting, authoritatively, on health within this wider definition of health promotion. Educators have a voice in commenting on substance-abuse programmes (Vertinsky, 1989). Management consultants write about adopting "health policies" (Deacon, 1990/1, p. 7) for the work place in which management attitudes affect employee productivity.

Nursing has not been immune to the allure of independence, particularly from the traditional medical model (Duffy, 1988; Tansey & Lentz, 1988; Anderson & Tomlinson, 1992). This point was raised earlier in the introductory chapter. As a clear example of the intertwined nature of professional goals for a 'new identity' and the insecurity over how nursing can be enacted, expressions of 'independent' nursing functions reflect the ambiguous state of this 'autonomous' position for practice.

A program evaluation conducted at a drop-in clinic by Dyne and Laurence (1989) offers an example. The clinic, staffed only by nurses, offered the following services:

> health assessments, on-going screening, foot care, health counselling (individual and group) and referral services to senior citizens (Dyne & Laurence, 1989, p. 38).

Following a survey-type evaluation, Dyne and Laurence reported that perceptions regarding the clinic's objectives were markedly different between service providers and service recipients. Nurses reported providing all advertised services except group teaching. In sharp contrast, the majority of the clinic's clients reported that they were receiving only blood pressure checks and foot care. The nurses were reported by the investigators as being "dissatisfied" (p. 38) with the clients' emphasis on foot care.

Expressions of 'dissatisfaction' point to a boundary which has been re-erected by these service providers who at the same time claim to offer a less traditional, more responsive form of promotional care than that offered by medical personnel. Unable to resolve the power dilemma by merely trading places with their more traditional colleagues, these studies suggest that programs suffer from the same pitfalls as the more traditional educational programs.

2.6 Attempts to avoid the 'problem' of power

The 'problem' of power sets up two different responses evident in the literature. In the introductory chapter these responses were referred to as the competitive versions of practice.

On one side of the debate are those who take the concept of health promotion as an opportunity for nurses to colonize an independent territory for practice. Health promotion is characterized as a way of legitimating access to client populations while at the same time developing a discourse for constructing 'the family', as a preferred site for practice, in particular ways. However, as both the medium and outcome of the practices they recursively organize, the mechanisms selected for colonizing sites for practice represent examples of what has previously been described as an instance of a structurated process. On the reading displayed in the foregoing sections, these structurated processes re-emphasize the importance of power in the constitution of practice.

On the other side of the debate are those who, while acknowledging the existence of power on the process of health promotion, conceive of power in only a simplistic way. By first locating power in the traditions of medical knowledge, they suggest that by removing the power of promotion from those particular individuals, the 'problem' can be solved. However, this insufficient conception of power only dislocates the influence of power into the bodies of less traditional practitioners.

Examples can be derived from the increasing literature claiming to examine empowerment in health care relationships (Wallerstein, 1992; Walding, 1991; Wallerstein & Bernstein, 1988; Dunst, et al., 1988), or social support networks (Stewart, 1990; Lynam, 1992). This section of the literature offers

examples where skills such as "listening" (Wallerstein, 1992, p. 204) are characterized in newly transformed ways. This process can be examined as an example of what Foucault (1975/1977) describes as "inversion" (p. 210).

> At first, they (disciplinary institutions) were expected to neutralize dangers, to fix useless or disturbed populations, to avoid the inconveniences of over-large assemblies; now they were being asked to play a positive role, for they were becoming able to do so, to increase the possible utility of individuals (Foucault, 1977, p. 210).

Listening, as an institutionalized practice used previously by nurses to demonstrate concern for the sick has now been transformed and put to new uses; it has been inverted, and now deployed in order to make people 'more well'. Wallerstein states that

> the curriculum [for the health promotion program] should not be prescribed, but should emanate from the listening process. Though this approach may not be completely possible due to funding constraints, at the minimum, curricula should be built around an opportunity for people to develop trust and to share real life issues and emotional concerns (1992, p. 204).

The curriculum is endowed with implicit notions of power. Wallerstein advises that it "should not be prescribed" but rather, allowed to emerge from the "listening process". However, this process of listening is treated as though it were neutral, and that topics of concern to those deemed to be powerless will emerge from this neutral process. While signalling the influence of power through availability of monetary resources in the form of program funding, Wallerstein's argument fails to consider the intricate conduits of power implicated in the inversion of the listening process from one of comfort measure, as it was previously construed, to the strategic device it has become.

2.7 Reconceptualizing power

The recognition made by Wallerstein (1992) that listening can be turned to strategic use in interaction is significant in terms of the present thesis because it stands as an example of how power is tightly insinuated in institutions of modernity. The conditions enabling strategic action are the same as those used to effect others understandings of those acts or the acts they describe. Nothing can be gained by conceiving of power as a 'problem' to be avoided. This is to fall into

the trap of conceiving of power as merely constraining. It is only through power that we can *see*, in Foucault's sense, at all. A brief excursus will develop this notion of 'seeing' so that it can be raised again later in the thesis.

Based on historical investigations of medical knowledge, Foucault (1963/1973) develops the notion of 'the gaze'. He noted that running beside developments in clinical methods for diagnosing disease was a shift in the way in which diagnosis was accomplished. In the middle of the eighteenth century disease was described in language which could only guess at the mysteries of the unknowable vessel of the body. In the space of less than one hundred years the language of diagnosis had transformed. In Foucault's terms the 'new' language of diagnosis,

> with its qualitative precision, directs our gaze into a world of constant visibility (1963/1973, p. x).

The body had become 'available' to medical practitioners in ways not previously conceived. The body's availability facilitated a transformation in the ways in which knowledge about the body was constituted. Foucault is not marking merely a change in technique. He is not saying that with 'better' equipment diagnosis 'improved'. Instead, he is pointing to a facility much wider than the technical. He is pointing to an entirely new gaze, a perceptual alteration, a mental roadblock perhaps which was overcome at the turn of the nineteenth century. This alteration not only makes a new way of 'seeing' possible but in fact *drives* that seeing. Wallerstein's warning that in order to develop a suitable curriculum for health one must 'listen' must be understood as a present-day effect of this perceptual alteration. For what the listening is going to do now is to 'make visible' to those equipped to see, possibilities "for people to develop trust and to share real life issues and emotional concerns" (Wallerstein, 1992, p. 204). The crucial point to be grasped is that this process of 'making visible' is an effect of a powerful "gaze".

No matter whose perspective is privileged, there will be an attending "gaze", for, as Foucault has noted,

> it is the sovereignty of consciousness that transforms the symptom into a sign (Foucault, 1963/1973, p. 93)

It is important to underline that the gaze enables *as well as* constrains production of meaning and procedures of categorization. Mary Douglas has stated that

> our colonisation of each other's minds is the price we pay for thought (1975, p. xx).

Douglas describes what she takes to be Durkheim's error in conceiving of the relation pertaining between agency and structure, that is, failing to recognize that his writings on symbolic influences on thought patterns apply not only to primitive societies but equally to western, civilised societies. Eschewing a correspondence theory of truth, Douglas instead proffers an "active theory of knowledge" which

> allows full weight to historical and sociological factors. Herein, I suggest, lies the reason for its fragility. It eschews a solid anchorage; it is committed to movement and revision. By definition it runs counter to all common-sense theories of knowledge which support separate intellectual disciplines using lower orders of abstraction. In these, the bit of the cosmos under specialised scrutiny is being busily furnished with indisputable hardware. Each discipline turns its fundamental knowledge into a piece of professional property. The click between its concepts and the real nature they discover validates the practitioner's status (p. xix).

What Foucault has described as 'the gaze' is picked up by Douglas in what she calls the "fundamental knowledge" used by disciplines to furnish their techniques. The consequence of action in institutions of modernity, that of making things visible, must be considered as it impacts the development of health promotion strategies in nursing. As Douglas astutely points out, the drive to establish "a solid anchorage", while offering a haven from the "fragility" of a theory attending to difference, runs the risk of masking the "indisputable hardware" securing the professional position. An example of this from the foregoing literature review can be demonstrated in nursing's 'claim' on the family as a rightful location for health promotion practice.

The debate on health promotion will not be solved by merely shifting the boundaries from one set of disciplines to another. A more profitable way forward might be to acknowledge the inevitability of power which not only oppresses and constrains but crucially also enables and makes thought possible. Such directions

are suggested by a study such as that presented above conducted by Davison and his colleagues. It has been argued above that that study suffered from an insufficient theoretical basis for dealing with lay accounts of health knowledge. As a second major problem discernible in the health promotion literature, that is, accounting for behavioural change, the review now turns to examine that portion of the literature.

3.0 'Diagnosing' potential: attributing motivation for change

Nola Pender's work on the Health Promotion Model, represents the only nursing model developed and used widely in empirical research, which addresses itself directly to the promotion of patient health. As identified earlier in this chapter, health has been described by Fawcett (1984) as one of the four "concepts" underpinning the metaparadigm of nursing. The identification of the concepts of nursing, health, person and environment has not generated progressive topics for research. Instead use of these concepts has facilitated a particular form of organization of nursing thought thereby constraining the categorization of more general theories of nursing.

The identification of a "metaparadigm" for nursing establishes an expectation that all theories or models of nursing practice will have something to say about each one of the concepts. This 'obligation' results in the concepts often being integrated in a somewhat contrived manner if they are taken as something which has obviously, that is 'visibly', to be present in the theory. In the case of Pender's work health has been narrowly defined as those aspects particularly amenable to discrete intervention such as smoking cessation, stress reduction and weight reduction. As will be demonstrated below, this has significant implications for the practice relationship.

3.1 Development of the Health Promotion Model

Pender's model was developed and marketed as a nursing alternative to the Health Belief Model initially documented in the late 1950's by a number of researchers working in the United States. Its formulation is generally attributed to Rosenstock (1966). In the 1970's the model was revised by Becker (1974) and

has been used extensively in empirical studies aimed at determining the conditions surrounding individual decisions to take action in response to actual or potential threats to their health. Pender acknowledges the appropriateness of such a model for examining "health-protecting or preventive behavior" (Pender, 1987, p. 44) but states that it is "clearly inappropriate as a paradigm for health-promoting behavior" (p. 44).

By marking this distinction, Pender shifts the focus of her model towards an examination of what conditions surround individuals' decisions to make health behaviour changes which *promote* their health, not merely as a reaction against illness. An initial reading suggests that this is an important distinction to make. With the introduction of this model nurses are alerted that situations which encourage an individual to check with a health care professional regarding some troubling symptoms he or she may have been experiencing may be very different from situations which encourage an individual to choose to take up "health promoting behaviors" (p. 44).

3.2 The problem of defining 'healthy' behaviours

An initial problem with this perspective is however, the need to identify what will be understood to be "health promoting behaviours". A study conducted by Walsh (1985) using Pender's model focussed on the health beliefs of a group of runners compared with a group of non-runners. The results of the study of a total sample size of 140 (representing a 46.7% response rate to the questionnaire) found that 82% of the runners reported continuing to run even though they were experiencing pain. Over half reported feelings of guilt, anxiety and depression when they were unable to run. Of the total sample, 97% reported having received a running related injury, with 73% having received more than one injury. Five percent of the runners had required hospitalization as a result of their injuries.

'Testing' of Pender's model is undertaken within an experimental frame and therefore associated with statistics of the sort displayed above. The statistical results are embraced by researchers intent on establishing the 'validity' of the

model. As a methodological concern, these results will be problematized in the next chapter but will be treated with some scepticism here.

The dangers of associating health oriented behaviours (like running) with a concept like health are demonstrated in Walsh's study. Clearly there is no simple correlation to be made between running and health. On a variety of objective measures of health the responses to running reported by the sample in Walsh's study could not be said to be promoting their physical or mental health. And yet, based on the measuring tool, the Health Value Scale, advocated by Pender in the first edition of her book (1982), Walsh found that "runners placed a higher value on health and performed more health-related behaviors than did nonrunners" (Walsh, 1985, p. 355). So, while "valuing" health according to an objective measuring device, the individuals who participated in Walsh's study report many negative responses by qualitative standards.

Currie, Amos and Hunt (1991) report the results of interviews conducted with 400 respondents. The aim of this research was to describe "the factors which act as primers, triggers, facilitators and inhibitors of change within the context of daily life" (p. 444). These authors acknowledge that behaviours are changed for what might be considered "non-health related reasons" (p. 451), for instance financial concerns or a concern with one's appearance, and suggest, rather pedantically, that the definition of health taken by researchers can influence the findings. It is this concern with pin-pointing *causes* of change which subsequently creates 'problems' for the researchers. Relying on interview accounts from individuals who, in an earlier postal survey, indicated that they had recently made health behaviour changes, the authors focus on the limitations of such a method:

> it must be borne in mind that the analysis is on retrospective accounts and as such may be influenced by perceived success or failure of change ... (Currie, et al., 1991, p. 452).

The 'problem' of "influence" rests on a presupposition that there is an identifiable cause for the behaviour change which may be masked or in some way altered due to what are considered inherent limitations of 'subjective accounts'. The strong preference for clear, 'objective' evidence is apparent in a study such as this. Having identified the significant effect of social construction

regarding notions of health, these authors fail to consider the full implications of such an argument. They are left with a weak, relativistic claim regarding the aim of research being to link individualist accounts of health with an assumed underlying, and objectively derived, cause for behaviour change. While not drawing specifically on Pender's model, this study and the many which fall into a similar category of concern demonstrate this fatal limitation (Duffy, 1987a; Rootman, 1988; Able-Boone et al, 1989; Bertera, 1990; French, 1990; Miller, 1991).

3.3 Research efforts focussing on diagnostic potential of 'tools'

The problem of developing the sort of objective tool to measure the potential for making 'healthy' behaviour changes has been at the heart of work conducted based on Pender's model. Tools have been developed which attempt to measure "lifestyle and personal resources" (Hubbard, Muhlenkamp & Brown, 1984), "health beliefs, health values and health promotion activities" (Muhlenkamp, Brown & Sands, 1985), the "health diary" (Frank-Stromborg, 1986), "attitudes, subjective norms and intentions to engage in health behaviors" (Pender & Pender, 1986), "health conception" (Laffrey, 1986a, 1986b), and "health promoting life-style" (Walker, Sechrist & Pender, 1987). The large number of variables which the authors have attempted to either include because it was felt to be significant to the findings or to exclude because it was felt to bias the findings have created the problem for this group of researchers who aim towards generalizability in their findings.

For example, Hubbard, Muhlenkamp and Brown (1984) describe their findings as "puzzling" (p. 269) when marital status was found not to make a difference in the health practices of a group of elderly adults. This was particularly problematic for the researchers when in the previous paragraph they claim that this same group "scored significantly higher" than non-married respondents on the Personal Resources Questionnaire, part II (PRQ - II). This finding suggested to the authors that being married

> may be important to one's sense of having a socially supportive environment during later adulthood (Muhlenkamp et al., 1984, p. 268-9).

The authors are then "puzzled" when this supposed "supportive environment" does not appear, according to the measurement tool, to be linked with health practices in this group of respondents.

This is only one of several 'problems' identified by the research group. Sample sizes are not large enough to generalize from (Hubbard et al., 1984), sampling techniques require "cautious" consideration (Muhlenkamp et al., 1985, p. 330), results are not statistically significant to support hypotheses (Walker et al., 1987) and "key components" (Muhlenkamp et al., 1985, p. 332) from the model which were "thought to stimulate action" (p. 332), are conceived of as being absent in studies of health promoting behaviours.

It has been the search for the "cue to action" (Pender, 1987, p 68) which has represented the primary driving force behind this body of research. This search is based in the belief that all human beings are, at some level the same and therefore, comparable. Thus, for example, a group of well elderly people can be studied to determine what their health promoting practices are. The assumption underlying the recommendations arising from such a study is that this information can then be transferred to a population of presently unwell elderly in order to promote them to higher levels of wellness (Miller, 1991; Viverais-Dresler & Richardson, 1991).

While having made a contribution to the health promotion literature by acknowledging that there may be a different process involved in promotion than in prevention, research based on Pender's model has failed to fully capitalize on this crucial distinction. Studies conducted using Pender's model as a theoretical base can be seen as attempts at diagnosing health in order to produce a pool of knowledge which nurses can draw from in order to give out advice on to how to become 'more' well.

3.4 The 'problem' of motivation

Herein lies the problematic core of this body of research. The goal of Pender's model and subsequent empirical studies conducted based on the model has been the development of a "multivariate paradigm for explaining and predicting the health-promoting component of lifestyle" (Pender, 1990, p. 326).

The search for explanatory and predictive criteria has centred on the concept of motivation (Pender & Pender, 1987, Viverais-Dresler & Richardson, 1991). Motivation is characterized by Pender as something which is affected by the individual's perceptions of subjective norms or their own internalized belief system (Pender & Pender, 1987). With reference to Rosenstock and Becker's earlier work on the Health Belief Model, on which Pender's model has been based, Norman (1986) notes that

> attempts were made during the early development of the Health Belief Model to include a general motivational construct ... but because of problems in operationalization, this component has generally not been included in statements of the model or research on it (p. 56).

Despite the apparent "problems" in bringing a concept such as motivation into research on health promotion it remains a central concern to nurses drawing on Pender's model. Viverais-Dresler and Richardson (1991) conclude their article with the recommendation that

> additional knowledge of what motivates the elderly to practise healthy lifestyles consistently would be of benefit to nurses in their practices (p. 69).

Characterizations of motivation are obviously important in the study of health promotion, particularly in the climate of 'effectiveness' which much health care research is currently based. Those funding health care services want to know that they are putting their money towards practices which have been proved to be the most effective as well as the most efficient. From this perspective, a concern with being able to identify specific "cues to action" can be understood as being central.

Problems encountered in the research projects described above however, occur because of an inadequate conceptualization of the term motivation. Giddens (1976, 1984) offers a significantly different perspective on this term from the primarily psychological one adopted by Pender and her research associates. An examination of how motivation is conceptualized within structuration theory will assist in exposing some of the more fundamental problems with Pender's research project.

3.5 The social 'monitoring' of action

Hubbard, Muhlenkamp and Brown's (1984) finding of two seemingly contradictory responses reported as "puzzling" (p. 269) offers an opportunity to explore the nature of motivation. Within the framework of structuration theory, questions

> posed about intentions and reasons ... are normally only put by lay actors either when some piece of conduct is specifically puzzling or when there is a 'lapse' or fracture in competency which might in fact be an intended one (Giddens, 1984, p. 6).

Acting in the capacity of 'lay social theorists' these researchers are 'puzzled' by their findings. The puzzlement is generated by their particular 'gaze'. The 'gaze' informs their recognition, that is, their ability to 'see' the response given by the study population, as a lapse or "fracture in competency" (Giddens, 1984, p. 6). The 'problem' for these researchers is that this lapse forces them to decide upon the intentionality of the response. Theoretical considerations on the notion of motivation are deeply divided. In this section, I will argue the case presented by the psychological perspective represented in Pender's model for action in contrast to the social action perspective developed by Giddens.

From within the functionalist framework which marks the responses given by the elderly respondents as "puzzling" for Hubbard and her colleagues, each human action is understood as being individually motivated. The reason why the authors found the results "puzzling" has more to do with the 'order' imposed by the research framework than any inconsistency on the part of the respondents.

A major component of structuration theory rests on the idea that human agents are involved in a constant mode of "reflexive monitoring of activity" (Giddens, 1984, p. 5). Actors are continuously involved in monitoring their own activities and operate under an expectation that other social actors do the same. Additionally, actors are said to routinely monitor both the social and physical aspects of the contexts in which these actions are taking place. This is important to understand because, under the guise of this monitoring of actions, actors will be at pains to reduce instances of contradiction, as contradiction demonstrates a lapse in competence in the social world. Thus, when we encounter

contradiction, it is more likely to be because our own expectations about the other actor have been jarred.

This perspective on 'motivation' suggests two possibilities: one can either attempt an explanation of action by virtue of something which can never be known with any amount of security, that is, psychological influences on cognitive processes, or one can collect accounts of action post hoc and treat these accounts as the giving of reasons for action. The latter are not to be treated as individual and relative accounts of some objectifiable truth, as they were by Currie, Amos and Hunt (1991). Rather, they are treated as social accomplishments, arising from within a theoretical framework for considering accounts as an outcome of the social monitoring process recursively constituting understandings of the social world (Garfinkel, 1967; Goffman, 1959; Giddens, 1984). The distinction is significant for the direction taken in this thesis and some further comment is appropriate.

Within the framework for explaining action offered by Pender and her colleagues, each action or behaviour is understood to be motivated by either an internal or external "cue to action". Such a perspective generates a linear, or causal image of human action. The tenacity with which this group of researchers has held onto the idea of discovering the motivation behind healthy behaviour change suggests a high level of commitment to this particular image of action. Their image of human action drives the research design, they constitute this image in the tools they develop and then recreate the image by describing the responses they receive with expressions such as "puzzling".

Giddens' view of human action attends in a much more sophisticated manner to the effects of 'the social' on human action. Rather than controlling the environment to such an extent where one fundamental cue for action might be identified, Giddens' framework explores the variability possible because of a central concern with the reflexive monitoring of activity. Rather than falling into a relativistic abyss, the fear which appears to drive Pender and her group towards behavioural and environmental control, Giddens claims that a chronic feature of social action is the reflexive monitoring of action and it is through this process that regularities of social action are to be detected.

From such a position Giddens' proceeds to claim that

> much of our day-to-day conduct is not directly motivated (1984, p. 6).

While human action is described as not directly motivated, it is constantly being monitored by ourselves and others. In most aspects of our day-to-day lives we are not asked to give accounts of our actions. Social action tends, for the most part, to be taken-for-granted by those monitoring our actions providing our actions fall within reasonable, that is, 'sense-able' limits. When respondents in any of the above studies were asked to give an account of their health promoting behaviours it is therefore quite likely that this would be a difficult thing for them to do.

3.6 Producing 'accounts' of action

For Giddens, accounts arise from two different sources. From within the discursive consciousness, we keep accounts 'ready-to-hand' for instances when we may be called on to give a report of our actions. This is not to say that this will even closely resemble the actions we have been involved in but it is a verbal expression of what the actor is aware of and what the actor expects will be accepted by the other as a legitimate 'reason' for the action under question. Such accounts can be understood as reasons which are commonly drawn on in order to explain our behaviour, that is, those that 'work' for us to assist us in day-to-day encounters. For instance, a surgical nurse does not have to ask for permission to negotiate entrance to a patient's room to conduct a treatment. She may 'account' for her presence by stating she wants to "do your vitals" but this is understood, within the framework developed for this thesis, not to correspond with an objective truth but rather as reasons which 'work' for the nurse to enable her to proceed with her plans.

Accounts arising from the discursive consciousness informs the observer about the actor's understanding of the world. Because the actor is understood as concerned with 'going on' in the world, these discursive accounts are selected by the actor to facilitate this process. Therefore, discursive accounts can be understood as those which the actor has worked out in practice as being most

effective to make moves across space and time. It is in this sense that discursive accounts can be treated as 'strategic' devices (Giddens, 1984, p. 290-1).

Contrasted to this is the practical consciousness where beliefs about social conditions especially those in which the actor is immediately involved in are located. The practical consciousness is central to Giddens' understanding of agency. Everything an actor needs in order to "go on" (1984, p. xxiii) in a socially constructed world is held within the practical consciousness. So, although it is drawn on in order to act in the world, by way of constant monitoring of one's own behaviour and that of others, none of this information is available at the discursive level. This is not to say that the levels of discursive and practical consciousness are anything other than fully interpenetrated, a position adopted by Giddens, but one which shows some inconsistency in his writing (Munro 1991a).

An example of how the discursive and practical consciousness can be understood in practice is offered. A nurse may provide directions on the feeding of two children of the same age to two mothers in two entirely different forms, one vague, the other highly specific. While at the completion of these two interactions the nurse may discursively report that she has "completed the assessment" or has "done some teaching", the difference in the *form* of this action can only be accounted for on the basis of some differences encountered by the nurse during her monitoring of the two different situated encounters. The crucial point to be grasped is the underlying interdependence between the agent and structural aspects constituting agents' performances in interaction which this idea of accounts suggests.

As the foregoing review of Pender's work indicates that differences understood within the context of this thesis as arising from acute and knowledgeable social monitoring, are attributed by Pender and her associates to unknowable psychological effects such as a "cue to action". As a psychological effect, the "cue to action" is incapable of being empirically substantiated.

Equally problematic is the alternative for attributing these socially constituted differences in which a washed out understanding of 'context' is used to explain difference. An example of this effect is Luker and Kendrick's (1992)

study in which the authors generated a list of 35 "sources of influence on clinical decision making" (p. 466) identified by community nurses. Drawing on statistical measures to support their research method, the authors claim that three-quarters of the nurse's decisions were influenced by "situational variables" (p. 463). These variables are not identified nor are they explored regarding the nature of the influence apparently exerted. The authors' repeated apologias for their "reductionist" (p. 460) approach has an interesting effect. The reductionist approach claimed to underpin the research design serves to invest the 'findings' with greater security in that a 'whole' has been broken down into constituent 'parts'. Again, the effect of a gaze concerned with visibility can be seen to be at work. Suggesting that the whole hides the effects of practice, reducing the whole to parts suggests a clearer view of practice might be obtained. Then by failing to examine the part labelled "situational variables" any further, the security of the seeing is retained but only by not problematizing the notion of what the practice situation or context consists of.

The most obvious problem arising from the research perspective taken by researchers who approach nursing practice as a rationalist, cognitive process; a process which can be mapped through investigations into psychologistic versions of motivation, is the almost total exclusion of social knowledgeability in the surveys they report on. Further research drawing on Pender's model as a theoretical framework can only provide additional information on what the researchers themselves believe about health and its promotion but little in terms of how individual social actors may act to be more healthy. As Roberts (1991) astutely points out, such perspectives aim

> only to improve the quality of the mirror image -- to polish and clarify its techniques (p. 355).

In contrast to these approaches, structuration theory takes the critical examination of the mirror as its central aim. Structuration theory offers a way of treating accounts of action as a bridge from which both agency *and* structure can be given critical consideration as they impact the construction of social reality. Drawing on accounts from both the discursive and practical consciousness Giddens' framework seeks a way in to studying social action through fractures in

accounts of that action. Rather than treating these fractures as 'problems' to be avoided or overcome by retreating into spurious scientific rhetoric, structuration theory takes these fractures as a starting point for critical analysis regarding the conditions of possibility for action.

4.0 Clearing a 'site' for studying practice

Reviewing a wide range of literature focussing specifically on the notion of health promotion or more broadly on views pertaining to nursing's position with regard to undertaking health promotion as part of its professional remit, the aim has been to clear a 'site' for a more critical examination of nursing practice. To that end, the review now returns to examine the four organizing constructs as identified by Fawcett (1984), that is, nursing, health, person and environment, in order to situate the position taken in this thesis.

The review has identified two major weaknesses in much of the theorizing about health promotion and perhaps particularly in the theorizing of health promotion as an act engaged in by nurses with clients. These two weaknesses are a lack of concern with the influence of power as not only a constraining factor on the relationship between the nurse and the client but also as power pertains to the constitution of subjects of and for promotion.

Secondly, the review points out major limitations in present conceptions of action, that is, action tends for the most part to be viewed in a tightly controlled way and as a result is characterized as a highly exclusive, rather than inclusive, notion. Social knowledgeability and its effects on action are excluded in favour of conceptualizations of action as fundamentally motivated by psychological factors. These, it has been argued, are ultimately 'unknowable' and thus represent an insecure basis upon which to formulate strategies for a practice discipline. From this perspective then, the review will conclude by returning to examine Fawcett's central features of nursing theory in light of these limitations.

4.1 Positions for understanding knowledge and power

A particular position has been advanced in this literature review with regard to the relation between power and how understandings in practice are

accomplished. With this in mind, it is concluded that references to person, nursing, health and environment advanced in the literature have failed to be pinned down due to an inadequate treatment of power and its effects on the constitution of knowledge in practice.

In this review, the position put forward has been that the practice relationship, at times explicitly described, at others only implied, is not founded on an inherent 'truth' but rather, represents attempts at 'ordering' objects nurses deal with in their practice. It has been demonstrated, with reference to general nursing as well as more specific health promotion literature, that the practice relationship is presently characterized as an effort to extend the legitimate territory of nursing practice and prescribe specific strategies for use within this new territory. Wallerstein's paper on empowerment was demonstrated to stand in contrast to much of the literature available in that it gives consideration to power at all.

However, in attending only to those resources surrounding the practice relationship and not the relationship itself, it falls well short of a critical analysis of how power not only constrains practice but importantly, how it forms and gives shape to practice, that is, the constitution of person, health, environment and nursing within particular practice settings. Without an account of power, none of these (so called) central concepts of nursing practice can have meaning. In the misguided emphasis on attempting to define nursing practice (Schlotfeldt, 1987) there has been a systematic neglect of the notion of power and its constitutional effect on nursing practice as an instance of social action.

4.2 Accounting for social action

In order to achieve such a critical analysis, understandings about the nature of practice are up-rooted. The literature is particularly striking in its emphasis on action characterized as solely embodied in the client or patient. Such an effect, I would argue, results from naive notions of power where the nurse is taken to be merely the receptacle of physiological and psychological knowledge aimed at facilitating healthy action on the part of the patient. Such a view of agency is static and ignores the part played by social 'inter-action'.

Of concern in this thesis is an attempt to explore the constitutional effects of 'the social' on action in practice. In this regard, health promotion has been taken as an example of a relatively 'new' concept which the discipline of nursing has demonstrated some amount of interest in engaging with as an element of their practice. However, lacking an adequate conceptualization of power to account for how "interests" (Wildavsky, 1992) are supported in particular social contexts, the central concepts deemed to give definition to practice (that is, nursing, health, person and environment) have no meaning. Projects such as Pender's work on the Health Promotion Model for nursing practice can only ever represent a limited aspect of this practice, lacking both a conceptualization of power and social action as a complex, inter-relational effect located within a social context.

Giddens' position on social action was contrasted with present conceptualizations of the practice relationship as an action-centred phenomena. De-coupling motivation from an individualist account of action, it was suggested that a more useful avenue for exploring the constitution of health promotion as action in practice is to consider action as emerging from the duality of structure in which structure is given meaning and comes into being in a social context only through the agency of the members engaged in the practice. By avoiding the limitations inherent in a dualistic account of action as *either* objectively *or* subjectively 'knowable', it was argued that only by obtaining accounts of action can the theory which drives practice be secured.

The review of literature has illuminated two central, inter-related problems in present conceptualizations of health promotion as an action constituted within nursing practice. First, the systematic neglect of the nature and effects of power in such constitutional work and second, extremely limited conceptions of action with resulting lapses in the ability to account in a meaningful way for action arising out of and constituting nursing practice.

Having cleared a site to locate the present study, the discussion turns in chapter three to a more detailed examination of the notions of power and action as they are dealt with in examples of empirical research into nursing practice.

Based on that critique, proposals for a robust examination of health promoting practice will be advanced in chapters four and five.

CHAPTER THREE

Entering the Field:

theoretical and methodological considerations

> As Celia bent over the paper, Dorothea put her cheek against her sister's arm caressingly. Celia understood the action. Dorothea saw that she had been in the wrong, and Celia pardoned her. Since they could remember, there had been a mixture of criticism and awe in the attitude of Celia's mind towards her elder sister. The younger had always worn a yoke; but is there any yoked creature without its private opinions?
>
> G. Eliot, Middlemarch (pp. 37)

1.0 Introduction: research methods and the exclusion of the social

'The social' is missing from the body of literature which purports to account for the way nursing practice is produced and reproduced. Within a practice based discipline such as nursing, work is accomplished between social actors. Entering the literature however, to discover the 'how' of practice, it is common to find largely prescriptions for improved communication skills and alternative definitions of nursing concepts. Only marginal attention is given to how practices such as health promotion are accomplished. This marginality arises, I will argue, from an exclusion of 'the social'.

In an important sense, the social can never be erased. It can be displaced, marginalized but never completely effaced (Munro, 1993a). In some literature, traces of 'the social' supplement the text as intrusions. The intrusions are then 'handled' by the researcher to justify their exclusion. For instance, Hubbard, Muhlenkamp and Brown's (1984) study, introduced in the previous chapter,

examined health practices of elderly individuals living in the community. The researchers found that the instrument applied to this group provided "puzzling" (p. 269) results. That is, inconsistent measurements of variables could not be explained by the researchers. Rather than looking towards the 'life-world' (cf. Schütz, 1967; Habermas, 1985/1987) to gain further understanding of this problem, the researchers returned their scrutiny to the instrument used to measure the population. They suggested that individuals may define "social support" (p. 269) differently during their life time. This hypostatization of a new category, "social support", then leads to further differentiation of the instrument, sub-dividing it into arbitrary age groupings; collecting more and more tiny pieces which fragment the analysis and lead the authors away from, rather than to, the desired prediction of individual "performance of specific positive health practices" (p. 266).

Paradoxically this fragmentation of the individual's experience of "social support" is presented by Hubbard and her colleagues as a necessary first step towards universalization, that is their ability to make claims about all individuals. In the discussion of their results the researchers state that even though the hypothesis was

> supported, ... generalizations presented here are tentative (Hubbard, Muhlenkamp & Brown, 1984, p. 268).

A concern for ever more precise measurements of ever more minute variables is reproduced. Yet results are never to be treated with anything more than caution. The rhetoric of knowledge production, pointed to by a reference to the findings having "supported" the hypotheses, is presented as conditional on further development and refinement in measurement technology. The activity of instrument development and implementation pre-occupies these researchers. This pre-occupation is reproduced in the text of the report, privileging the production of technology over the life-world of the 'subjects' of the research. Knowledge is implied to ultimately benefit the health care recipient through the nurse as the consumer of the techniques. The focus on production of technical instruments ignores the life world within which such instruments will be implemented at both the production and the consumption end.

Methods which privilege the technical effectively exclude examinations of the influence of the construction of health care through social interaction among individuals in the community, health care workers in organizations, and particularly at those times when the worlds of each intersect. Examination of the understandings emerging from such interactions are obscured from view. Only an abbreviated and displaced version of how social action constitutes nursing practice is revealed. Suggestions for change in social action are severely restricted if they are derived from a study which has excluded 'the social' from both the research design and the reported results. Unless a more radical critique is undertaken of the ways in which exclusion of 'the social' is currently managed in research of nursing practice, the slide towards ever more technically-oriented practice will continue.

1.1 Theoretical backdrop for the chapter

The position taken in this chapter is that methods currently advanced in the nursing literature for gathering and analyzing data, are constituted by theoretical notions which themselves exclude 'the social' from understandings of nursing practice. This claim follows Giddens' (1984) central notion regarding the duality of structure in which structural properties are understood to be drawn into social systems by knowledgeable agents. This is taken to mean that social systems do not exist outside of action, but rather, are implicated in the production and reproduction of those systems (Giddens, 1984, p. 24-29). Taking researchers as social agents who construct their world through the same processes as all other social agents, the argument I will advance is that researchers have drawn on structural properties which exclude 'the social' to constitute their approach to the life-world in which practice takes place. Knowledge arising from research technologies which exclude the constitutional effects of social encounters, in turn constitute theoretical notions about nursing which exclude 'the social'.

The theme is one of 'orders of knowledge'. Reflecting upon Foucault's writings (1966/1970, 1969/1972) regarding this central theme, the position taken in this chapter is that practice does not require organized knowledge in the form of theory in order to justify it. Rather, practice stands empirically as instances of

theoretical accomplishment. Theory is taken as representing embedded orders of knowledge enacted by members engaged in social contexts and recognized by other members of the context as nursing practice.

The theme of 'orders of knowledge' will be extended to demonstrate how currently advocated methods for studying nursing phenomenon are drawn on recursively to constitute a body of knowledge which excludes the dimension of the social from nursing practice. The aim of this chapter is to provide an account of methods which can be expected to render a description of practice which re-orientates 'the social', returning it to its *constituting* position in discussions about nursing practice. The investigation which follows arises from the stance that methods used to gather data, to constitute that material as 'data', are inextricably linked with the understandings of that data in the form of analysis. That is, underlying this discussion is the premise that the constitution of research technologies as 'method' relies on the same strategies for accounting as do the methods for accomplishing the fieldwork and the analysis of the data arising from that method. In line with Garfinkel's (1967) conceptualization of knowledgeable practice, what is being suggested is that a researcher's account of the conduct of a research project is available for analysis in the same way as are the practices which that researcher claims to capture as 'data'.

In this chapter, two major studies of nursing practice generated by field methods will be examined to demonstrate how 'the social' is affected by theoretical presuppositions about agency, action and structure. In this way, the major points of departure suggested by a more radical approach which *includes* 'the social' will be illustrated.

1.2 Theorizing 'accounts'

A comment on the theoretical treatment of 'accounts' in this thesis is warranted. An examination of how agency and structure are constituted as part of the research design can be informed through a critique of the 'accounts' made by researchers about their methods of studying nursing phenomena. Nursing practice, as it comes to be 'ordered' through decisions made about the conduct of the research project, becomes available for study. Garfinkel's (1967) treatment of

everyday activities relies on a pragmatic framework in which actors are viewed as being much more 'knowledgeable' of the ways in which they constitute the social world than their verbal accounts would suggest. Garfinkel's work on ethnomethodology, drawing on Schütz' development of the notion of shared stocks of knowledge, informs the present thesis as it illustrates the extent to which activities of researchers studying social encounters can be understood as operating on the same principles as the activities of social actors engaged in health care situations.

The 'methods' constituted and selected by actors in the everyday world, whether nurses assessing a child's developmental status, parents attending an immunization clinic or researchers studying nurse-client interaction, are available for study through the collection of accounts and the examination of these accounts with reference back to the context from which they emerge (Garfinkel, 1967; Giddens, 1984). 'Accounts' are taken in this thesis to be the giving of reasons for actions. They represent the moral order in which actors constitute the "natural facts of life" (Garfinkel, 1967, p. 35). What Garfinkel explicates so clearly in his "demonstrations" (p. 38) of trust is the extent to which social actors 'trust' others when they meet in interaction to follow the moral order assumed to hold for all actors; the "stock of knowledge" in Schütz' (1967, p. 20) terms. Garfinkel speaks of this 'order' as "what every member knows" (1967, p. 36-38).

Of particular interest then in research which attempts radically to draw out 'the social' in practice, will be an excavation of the moral order produced and reproduced between members engaged in interaction. Actors are acknowledged not as "judgemental dopes" (Garfinkel, 1967, p. 67) but rather as members approaching interactions from an attitude of the "natural facts of life", assumed by both members to hold in any specific interaction. That is, they approach a social encounter as socially knowledgeable members of society. This position holds when examining a researcher's account of a research project just as it does with actor's accounts of action given to a researcher or to other members within a social setting (Garfinkel, 1967, p. 35). In all cases, 'reasons' are given within a

frame in which those reasons are constituted by the individual accounting for action as being adequate for the purpose required.

The facility demonstrated by members of social encounters to 'account' or 'give reasons' means that at times verbal accounts and physical action may not exactly correspond. In fact, this correspondence may appear quite loose. For instance, a community nurse may give an account of her interaction with an elderly patient as an instance of 'patient teaching' when what was observed by the researcher might be the nurse writing down the names of four drugs the patient reports having been prescribed by her physician. That the behaviour and the account do not correspond for the researcher is not to suggest that the connections between these two aspects of social behaviour are anything less than fully interpenetrated (Munro, 1991a). This is suggested, but perhaps not pressed to its fullest extent by Giddens' when he claims that "there is no bar" (1984, p. 7) between the discursive and the practical consciousness.

The crucial point for Giddens is that verbal accounts of action given by social actors arise, under most circumstances, from the discursive consciousness. Only in 'unusual' circumstances, for instance when a social actor is 'called to account' for his or her actions, will there be some reflection resulting in the formulation of accounts which may not previously have been offered. These accounts reflect access to the practical consciousness and can be understood as accounts which, as the usual account did not suffice, draw on understandings of the event in question as well as understandings the social actor holds of him or herself and the other who has asked for the account. Knowledge of these circumstances is drawn on by the actor to construct an account which, he or she assumes, will do more work in the particular circumstances.

Discrepancies which (commonly) occur between agent's accounts of actions and the actions observed by others (including social researchers) then, represent pivotal moments when the moral order can be examined. On the above analysis, the account given by the actor is understood to draw from, and therefore reflect, his or her understandings of the circumstances in which the account has been sought. The analyst's aim would be towards explaining the

conditions upon which such 'orders of knowledge' become deeply embedded in the production and reproduction of institutionalized practices.

Knowledge can be dis-embedded from verbal accounts arising from the discursive and practice consciousness, as well as from accounts made by researchers of observed social action. The position taken in this chapter is that by attending to the knowledgeability of the actor, the social constitution of nursing practice is moved from the margins to a central position for study.

1.3 Empirical accounts of nursing practice

The first study to be examined is that conducted by Field (1980) for her doctoral work. Three articles based on the study have been published by Field. These will also be taken into consideration (1983, 1987, 1989). Field focussed her study on nursing practice conducted in a community nursing clinic in an urban Canadian setting. Demonstrating a scepticism regarding formal nursing theory all too infrequently found in the nursing literature, Field's premise upon entering the practice setting was that nursing actions were informed by a "perspective" (1983, p. 4) deemed to be heavily influenced by "the nurse's own life experience and priorities" (p. 9). Of particular interest to Field was an attempt to categorize nursing actions observed in the community clinic setting as health promotion, prevention of illness or crisis prevention. More recently (Field, 1989) she has attempted to link these categories with levels of expertise drawing on the work of Patricia Benner (1984). The discussion which follows focuses on the effects of Field's analytic task of pressing data into pre-established categories and the implications of her recommendations for more efficient production of 'experienced' nurses.

The discussion then turns to examine Benner's (1984) conceptualization of practice more fully. Benner has re-discovered the concept of 'experience' within the realm of practice and attempts to incorporate it into a descriptive account of how nurses develop expertise in practice. Particularly due to her attention to the place of language in this process of developing expertise, Benner's study offers an opportunity to uncover how she constructs expertise. Benner's study is used to clarify understandings regarding relationships

pertaining between language and the constitution of action prior to outlining the particular methods used for conducting the study reported in this thesis.

Ultimately, the critique conducted in this chapter aims at determining the kind of questions to be formulated in order to provide an account of nursing practice which does not limit itself to a description of practice; an approach which does not exclude matters pertaining to the social constitution of that practice. By offering an account of the way understandings of nursing practice are arrived at and the effect of these understandings on the constitution of nursing action, a study such as that reported by Gott and O'Brien (1991a, 1991b, 1991c) offers an example of the way in which understandings of practice have begun to shift and the resulting the direction which research could take.

As will be demonstrated shortly, the problem with Gott and O'Brien's work as with Field's is that they recommend changes to the educational system as a way out of the 'problem' of what they ultimately describe as a failure of an idealized view of practice. Such remedial reactions to 'problems' identified as a result of research suggests an underlying pathology in the critical abilities of the researchers. While having accomplished a shift away from the foundationalist perspective of viewing practice as emerging from theoretical notions imposed from above, they demonstrate a retreat into a functionalist perspective which relies on the constant call to re-train workers.

It is noted at the outset that the major contribution of researchers such as Field and Benner lies their scepticism of the foundational perspective whereby the production of knowledge, reproduced as 'models' of nursing, are taken as 'guiding' practice. This latter perspective is viewed within the context of this chapter as privileging a technical orientation to practice. The discussion which follows will demonstrate however, that the shift away from foundationalism may be insufficient to avoid the 'danger' of falling into a functionalist perspective as clearly demonstrated in the remedial 'treatment' suggested by these authors (Field, 1989; Gott & O'Brien, 1991c). The chapter, in advancing a more radical account of social action, will demonstrate that limitations of both the functionalist and foundationalist perspectives can be avoided through an account which addresses the extent to which 'the social' influences action.

2.0 Field's ethnography: the 'identity' of logical, progressive practice

Field's 1983 paper is an essay on her method, ethnography. It will be examined as 'an account' of the ethnographic method in its own right. Field's analyses of community nursing practice provide some clear examples of a study concerned with the "logics of identity" (Maffesoli, 1989, p. 2). Data arising from fieldwork are pressed into pre-existing categories in order for actions to be "identified" as either similar or dissimilar to one another. Field then manages intrusions of 'the social' since some aspects of the practice observed do not 'fit' neatly into the three categories of 'health promotion', 'illness prevention' or 'crisis prevention'. As with the study by Hubbard, Muhlenkamp and Brown (1985) discussed above, Field 'notices' inconsistencies in the accounts of practice she has observed. However, these 'notices' of intrusions remain excluded from her theoretical formulations about the group of workers she studies.

Field's treatment of the inconsistencies demonstrates her reading of them as having marginal impact on her interpretations. Morris (1992) claims that pushing accounts of action into the margins, accounts which are taken within this thesis to represent the outcome of a complex reading of a contextualized moral order, is to negate the social implications of the inconsistency. The "slippage" (Morris, 1992, p. 256) from complex social action, informed by a constructed moral order, to a surface 'defect' ensures that alternative readings of these inconsistencies become "unreceivable" (p. 256). The result for Field's research is that she claims that once a community health nurse developed a perspective for her work "it appeared to be relatively resistant to outside forces" (Field, 1983, p. 9). Standing as her major finding, Field includes in the same paragraph that "when agency policies conflicted with the nurses' beliefs they devised strategies for circumventing the policies" (1983, p. 9). Field treats the work accomplished by the nurses to circumvent policies as a surface defect. The finding is "unreceivable" as a finding. It is marginalized since Field's premise about agency and action already exclude such signs as findings.

This demonstrates one of the mechanisms at work when social aspects 'intrude' into what has been designed as an orderly, tidy study by the researcher. In the work of marginalizing 'intrusive', messy aspects which the researcher's

methodological framework does not account for, something else is revealed. Commenting on the danger of naive relativism which Field's position reflects, Rosen (1991) observes that

> The authority of an interpretation is never absolute, its value does not rest on whether an alternative explanation can account for the same data. Instead, its value rests on whether the explanation accounts for the data in a plausible manner, or whether we are able to provide our own accountings for the reported data. An ethnographic work is valid even in this latter case, for the goal of generating meaning for the cultural data of another is accomplished (p. 2).

A study such as Field's is important as it "generates meaning", which, while her own method is not capable of accounting for it, points to the impossibility of effacing the social as I have already argued.

Intrusions of 'the social', deferred by Field, can be retrieved as Rosen suggests, to generate "meaning for the cultural data of another". Field's treatment of the intrusions can be examined as can the intrusions themselves.

2.1 Constituting 'data'

Field presents the aim of her study as an investigation of the "factors that influence and direct the nurse as she provides care to clients" (Field, 1983, p. 3). She takes "symbolic interactionism" (p. 4) as her theoretical framework. Within this framework Field conceives of the 'self' as being accessible through verbal accounts. The stated purpose of discovering "factors that influence and direct the nurse" is linked to development of educational technologies which will "force [nurses] to make conclusions based on the assessment they have made" (Field, 1987, p. 564).

Field's research aim arises from a belief about human action resting on the premise that each individual 'constructs' action in conjunction with a 'self' which is understood within the functionalist perspective as 'normative'. Field would have it that action is informed by normative beliefs located in some external 'reality'.

Field's approach stands against the perspective advanced by Garfinkel in which action is framed by socially constituted moral orders; orders constituted internally, by the self, but empirically accessible through accounts, based on

readings of other social actors. The result is that Field's perspective excludes from the start the influence of 'the other' as having any authority on the outcome of the interaction. Already, Field has marginalized 'the social' from her study of nurses' practice.

2.1.1 Marginalizing 'agency'

Field describes social relationships between nurses and patients in a mechanical way. She describes in narrative form her observations of a nurse working with a patient named Charles.

> Another client, Charles, chose not to take his pills because he knew drinking and drugs were contraindicated. *Because he made a conscious* decision, Brenda *turned her attention* to helping him examine the effects of drinking. *On the basis of that information, Charles decided* to see a psychologist and eventually attended an alcohol counselling clinic (Field, 1989, p. 21, emphasis added).

In this example Field orders the account by focussing on nursing actions. These actions provide legitimation, by means of the presentation of a 'logical' progression of action following from the nurse's interpretation of Charles' "conscious decision" not to take his pills. Field does not question the basis of the nurse's action. She treats the nurse's action as falling within meaningful 'stocks of knowledge' assumed to be held by all nurses.

Concealed in the account is the reproduction of power in this situation. Field's legitimation of the action taken by the nurse reveals a moral order underpinning her analysis. Structures of signification are marginalized in the drive to present an orderly, effective series of nursing actions. The ordering of the account with the resulting marginalization of structures of signification, legitimation and domination effectively denies the agency of the social actors. Social actors are characterized as merely responding to a shared, pre-existing social order which they themselves have no part in creating. This is inconsistent with Field's statement that her study is informed by the social interactionist perspective in which human action is viewed as having been "constructed" (1983, p. 3) by the self. The result of such an approach is that reader is left out of the 'how' of this particular example of nursing-patient interaction.

2.1.2 Implications for 'action' and 'structure'

Field describes two levels at which ethnographic examination can be undertaken. In the first, surface structures of society are described. This data is characterized as observational. The second level, obtained by "probing under the surface" (1983, p. 3), is said to examine meanings and motives underlying social action. Field obtains this information by interviewing nurses following observation periods. Action is characterized by Field to be motivated from deep cultural structures residing outside the individual but constituted by the individual in actions observed "at the surface" (1983, p. 3). Theoretically, Field returns agency to the self. Nonetheless, when used as an analytic device on empirical data, agency remains marginalized by Field.

Field's account of the actions taken by nurse Brenda in response to Charles' "decision" not to take his pills demonstrates a functionalist approach and is evidenced by Field's one-dimensional understanding of action. First, Charles' 'decision' to not take his pills is characterized as *causing* Brenda's action of "helping him examine the effects of drinking". Second, on the basis of Brenda's "helping" activities, Charles is said to have "decided" to see a psychiatrist. Field ascribes a spurious 'causal' link between the nurse's work and the resulting effect on the patient. The link is made possible only through Field's direct intervention of "translating" (cf. Latour, 1986) the nurse's actions. Field's intervention, appearing in the text as an account of nursing practice, is only partially 'hidden' within references made by Field to her reported use of 'ethnographic techniques'. Direct intervention by the researcher in the form of 'translation' is contradicted within Field's understanding of ethnography.

Observations of work practices made by Field correspond with what she describes as the first level of ethnography, that is, a description of the "surface structures of society" (Field, 1983, p. 3). Field's approach of probing the nurse's accounts of these observed structures is claimed to provide support for the observations of action and, as such, represents the second, deeper level of ethnography: probing beneath the observed surface to ascertain meanings and motives. This is exemplified in the following description of factors which Field claims influence the model of nursing used in practice by each nurse.

> Ruth believed education to be an important part of her own professional development but she also saw her nursing education programme as strongly influencing her belief that prevention was the core of community health nurse. She had a commitment to her belief that was evident in the time she spent in prenatal teaching and committee activities (Field, 1983, p. 8).

In this description the two levels of ethnography, described by Field as reflecting the "new ethnography" (1983, p. 3), are brought together to produce an individual portrait of the nurse called Ruth. Field's interpretation, however, is based on an unacknowledged hierarchy.

Data derived from the "probing interviews" are presented as though *primary*, with the researcher's observation of action 'supporting' the nurse's presentation of self. Field, in effect, denies that the nurse's "perspective" (1983, p. 4) derives from the researcher's interpretation of the interview material. By placing her observations in the subservient position of 'supporting' the nurse's verbal account, Field denies the power she holds as researcher.

2.1.3 Analytic implications: exclusion of inconsistencies

The effect of this approach to ethnography results in a circularity, evident in the description of practice conducted in the clinical setting. While noticing inconsistencies between her observations and what the nurse accounts for as practice, Field's approach to ethnography suggests that observations made by the researcher must support the account given by the nurse. For instance, the following description is offered by Field of one nurse's work:

> Another of Carol's assumptions was that the public health nurse dealt with the well individual and moved them further toward positive health. Yet, in her school work, she frequently saw children who were already in a crisis situation, so much of her work could be classified as restorative ... While prevention (such as screening and immunization) and restoration were a major part of her work, Carol was alert to areas where promotion of health was feasible and she kept this as her goal even when her immediate activities were diverted. Thus, she maintained her perspective even though much of her nursing intervention seemed to contradict her beliefs about a well population and health promotion (1989, p. 6-7).

Field 'notices' that a significant portion of this nurse's work is not represented by the perspective she claims to hold and that which Field's epistemological stance would suggest is 'motivating' her actions. It is Field's position that the nurse's perspective, identified by the researcher through a combination of observations and deep probing interviews, holds the deep meanings and motives which guide the nurse's actions. Field suggests that Carol's work in the school "could be classified as restorative". The tentative nature of this statement arises because Field is locked into a stance which recreates the hierarchy of the nurse's verbal representations of work over the researcher's observation of that work. Field will only attribute the nurse's actions with those meanings and motives offered by the nurse herself. Carol has described herself as being motivated by a desire to promote health and so, although the work looks like "restoration" to the researcher, it is re-framed (with a large portion of the work now marginalized) as merely contradicting Carol's perspective. Field's report on this event is that the perspective is maintained.

The privileging of accounts given by the nurse results in the researcher's observations being used to "support" the nurse's claims. This reflects what Geertz has described as evading the "burden of authorship" (1988, p. 140). Field privileges the nurse's account of work over her own observations, effectively marginalizing any observations which do not 'fit' within the nurse's account. This is problematic.

Field's original premise is that the nurse's perspective is supposed to guide practice. However, as the examples demonstrate, Field states that the nurse's perspective is maintained even though the observed actions contradict the cognitive perspective which is claimed to guide practice. Field does not view this as an instance of 'falsification' (cf. Popper, 1972) of her theoretical position. Rather, she claims, by privileging the nurses' account (as a 'translation' constructed by Field herself) and marginalizing her own observations, that the perspective is maintained.

2.2 Re-orientating 'action' in social theory

Central to any approach which takes account of 'the social' in practice is a framework which accommodates contradictions arising between actors' accounts of action and the action observed by the social researcher. Giddens (1984) suggests that contradictions, exemplified in the foregoing analysis of Field's study, occur due to the interlacing of the discursive and practical consciousness.

> Where what agents know about what they do is restricted to what they can say about it, in whatever discursive style, a wide area of knowledgeability is simply occluded from view (p. xxx).

As suggested in the introduction to this chapter, Field's theoretical perspective has influenced her constitution of data *as data* as well as her analysis of the data collected. Field's decision to take the nurse's verbalizations about their work as superior to her own observations of that work, "occludes from view" the knowledgeability of the nurses and the patients in their efforts to make sense of and act in the situations described.

Field's study reflects an attempt to dispose of the burden of authorship, pushing it back on the actors whom Field has made it her business to study. This represents a denial of ethnography, not an exemplar of it. Field is attempting to redress what she views as the limitations of taking a subjective research approach (that is, her own interpretation of the events observed) by privileging the nurses' account of those events. Privileging the nurses' accounts derived from interviews however, represents a naive attempt to solve the problem. Field is claiming that interview data is more objective because it has emerged from the nurse and has merely been recorded (faithfully) by the researcher. By disposing of the burden of authorship, Field denies her own 'presence' as being as integral to the nurse's verbal account as it is to the description of the nurse's actions. Such a position is untenable as it is a denial of ethnography as Geertz conceives of it. To make a very old point, the researcher "enters the field" through participant observation. Any attempt to privilege objective 'facts' over subjective 'interpretations' denies the significance and the fundamental necessity of the researcher's entrance (for a thorough examination of 'presence' in observational accounts see Raffel, 1979).

2.3 Escaping the subject-object dualism

In chapter one structuration theory was introduced as an important contribution to social theory reflecting a synthesis of theoretical positions which offers an escape from the dualism of the 'objectivism versus subjectivism' debate. Rather than viewing these as inherently oppositional, Giddens conceptualizes them as a "duality" (1984, p. 25-28).

Structure can not be viewed as residing outside individuals as it is in Field's study. Rather,

> the structural properties of social systems are both medium and outcome of the practices they recursively organize. Structure is not 'external' to individuals: as memory traces, and as instantiated in social practices, it is in a certain sense more 'internal' than exterior to their activities ... (Giddens, 1984, p. 25).

Giddens presents structure as apprehendable from a position which views "action as *Praxis* " (Giddens, 1976, p. 53). Agents are constituted, not as victims of external forces, but instead as drawing on rules and resources in a knowledgeable manner to constitute structures in the social world.

Because structures are socially constituted by knowledgeable agents, "transformation points" (Giddens, 1984, p. xxxi) become the focus of attention. That is, those structures drawn on by actors to constitute change. Rather than accepting the nurse's discursive account of her activities as "health promoting" as holding a position of equivalence with her practical accomplishment of those activities, the researcher examines the account as reflecting what the nurse believes to be legitimate as an account of her activities. This account stands *beside* , not above or beneath, the researcher's observation of activities which constitute the field she has entered.

Field's functionalist approach retains the dualism of the subject / object opposition and, as a result, her text demonstrates the reproduction of 'inconsistencies'. For Field, inconsistencies are reproduced by the nurse's verbal accounts of practice being placed in a position of opposition because they are different from Field's observations of that practice. This leads Field to treat the actors as judgemental dopes. She denies the knowledgeability of the nurse who

accomplishes what she calls 'health promotion' by attending to certain signs emerging from the interaction between the nurse and patient. Field marginalizes this work by re-labelling it 'restorative', in the process inferring the nurse was merely 'mistaken' in providing her account.

Action is understood in this thesis as being constituted through the duality of structure. This leads the researcher to an explanation of social reproduction in the form of socially constructed routines. Individuals are not seen to have independent definitions of concepts such as health promotion as much as they have individual methods for accomplishing what comes to be constructed as 'health promotion' through the accomplishment of institutionalized practices.

The discourse of difference and change inherent in Field's account are not acknowledged by her, concerned as she is with developing "perspectives" of nursing. Studies of social action should be concerned with the development of methods to account for differences within space and time as well as an account of change over space and time. Field's inability to overcome the subject / object dualism has major implications for her ability to account for the differences and inconsistencies she is acutely aware of. The location and form of 'difference' and 'change' inherent in Field's work will be the focus of the next section.

2.4 Accounting for 'difference'

Field's study can be understood as a description of differences in the way nurses enact their practice. Field attributes differences exhibited by nurses in the work setting to differences in their "own life experience and priorities" (1983, p. 9). As evidence of the struggle she has with using experience as an explanatory device, internal inconsistencies within Field's account of the differences will be explored.

Having described the practice of nurses in this setting, Field was left with a 'problem'. The problem was that the nurses, while all taking what was described by Field as a "humanistic approach to health education" (1989, p. 21), accomplished their work with clients in what Field took to be 'observe-ably'

different ways. For instance Field claims that, Susan, one of the nurses participating in the study

> failed to identify the more covert needs [of her clients]. Her questions tended to deal with superficial information, and she did not perceive alternative cues if she was already pursuing another line of thought (Field, 1989, p. 23).

Drawing on Benner's levels of expertise to explain her findings, Field claimed that two of the nurses, Brenda and Beth, were enacting practice at the level of proficient practitioners while Susan was said to "function at the level of the advanced beginner" (1989, p. 23). Susan was also described by Field as "the youngest and most inexperienced of the three nurses" (p. 23). "Experience" then, Field claims, was "reflected in [the nurses'] ability to provide health education" (1989, p. 23).

Field claims that her intent in the study is to inform the reader about "what accounts for the differences" (1989, p. 20) in three practitioners approaches to health promotion. 'Experience' however, is not explored. There is no examination of how experience is attained. There is no explication of the mechanism in play between 'experience' and practice.

I would argue that what Field points to as observe-ably different practice suggests something about the nurse's skill and knowledgeability of operating in a social world. Acting knowledgeably in the world, the nurse makes "inferences" (Eco, 1984, p. 40) about the conditions constituting the work context. Alteration in work practices reflects these inferences. Field's treatment of this 'difference' fails to recognize the extent to which the material context in which interactions take place inform actors regarding the work being accomplished.

Field's treatment of the differences observed in practice locates that difference internally in some form of cognitive formulation which she describes as "values" or "perspectives". Social research has no direct access to such psychological constructions. If Giddens' point is accepted that a concept such as motivation cannot be apprehended in any secure manner (Giddens, 1976, p. 95-96), an alternative way of accounting for difference in social action must be advanced. In an effort to advance this alternative view, the discussion now turns

to examine the work of Patricia Benner to investigate her work on experience in nursing practice and its effect on differential practices.

3.0 Accounting for difference: Benner's levels of practice

Patricia Benner's work rests on the premise that actions taken by nurses represent the outcome of

> knowledge that accrues over time in the practice of an applied discipline (Benner, 1983, p. 36).

Experience then, is linked with knowledge which accrues over time. Experience is defined by Benner as

> the refinement of preconceived notions and theory through encounters with many actual practical situations that add nuances or shades of differences to theory (Benner, 1984, p. 36).

Benner differentiates this type of experience from the "mere passage of time or longevity" (1984, p. 36). Experience is privileged by Benner as the outcome of a reflective moment in which learning occurs through the awareness of difference. Yet, as the quote about knowledge accruing over time demonstrates, Benner has been unsuccessful in completely disentangling the concept of time from experience. It is acknowledged that the concept of time is considered problematic within the wider context of social theory as recently reviewed by Bergmann (1992) and Nowotny (1992). In the context of the present paper Benner's use of time as problematic within her own work as well as being the location of crucial errors in the uptake of her work by other writers will be examined.

What Benner suggests does occur "over time" is movement of an individual nurse through levels of practice starting at the "novice" and ending at the "expert" practitioner. These levels are described as a movement away from "rule-governed behavior" (Benner, 1984, p. 21) to behaviour which reflects the "intuitive grasp" (1984, p. 32) of a clinical situation, claimed to be indicative of "expert practice".

The lack of clarity in Benner's own work between observed behaviour and experience, as located in time, is picked up in Field's work. Field describes the nurse she calls Susan as "the youngest and least experienced of the three

nurses" (Field, 1989, p. 23). Although in her 1984 publication Benner specifically notes that expertise cannot be taught (p. 184), there is now a tradition developing in the nursing literature, as well as in practice, for her work to be used in this way (Calkin, 1984; Schultz & Meleis, 1988; Thorne & Robinson, 1988; McLeod, 1990; Darbyshire, 1991; Diekelmann, 1992; Lynam, 1992; Jacavone & Dostal, 1992). Benner's silence on this direction can be taken as supportive.

Field exemplifies this uptake of Benner's work by suggesting that through a process of "mentoring", novice nurses could be assisted to "become proficient in making judgements" (Field, 1987, p. 570). This claim rests on the naive assumption that if all the 'signs' picked up by a more advanced nurse are pointed out to the novice nurse, made 'obvious' to the novice, she will advance more quickly towards the expert level of practice. This ignores the significance and interpenetration of knowledge, context and experience, a theme which will be picked up presently.

3.1 The development of Benner's notion of 'experience'

Benner claims to draw on Gadamer's hermeneutics to ground her explanation of how nurses first *gain* experience, then *convert* that experience into knowledge and lastly *draw on* the stored experience-as-knowledge in future clinical situations. To the extent that this progressive chain of events underpins her claims about expert practice then, it must be clarified that Benner has not grounded her understanding of 'experience' in what Gadamer describes as "hermeneutical experience" (Gadamer 1960/1989, p. 358). Benner's claims about the 'progressive' nature of experience in nursing practice will be outlined and then contrasted with Gadamer's notion of hermeneutical experience.

Benner identifies five levels of practice which she claims nurses pass through prior to attaining expertise. These levels are novice, advanced beginner, competent, proficient and expert practitioner. These levels are taken by Benner to represent progressions along a continuum where the novice nurse's actions are said to reflect "rule-governed behavior" (Benner, 1984, p. 21) and the expert nurse's actions, said to be based on "an enormous background of experience, now has an intuitive grasp of each situation" (Benner, 1984, p. 32).

Benner has developed these categories based on the work of Dreyfus and Dreyfus (1985). They distinguish five levels of skill acquisition demonstrated by the activities of airline pilots in learning to fly planes and chess players in learning how to play chess. Benner's work is based on the verbal accounts of nurses asked to describe "critical incidents" (Benner, 1984, p. 16) experienced in their work with patients. Benner contends that proficient and expert nurses approach patient care situations with knowledge of previous critical incidents as "paradigm cases" (1984, p. 8). These cases stand out and are recalled by the nurses because, Benner claims, "they changed the nurse's perception" (p. 8) of similar sorts of patient care events. This is consistent with her definition of experience which, by adding nuances of difference to preconceived notions and theory, the nurse comes to view future clinical situations differently.

While having captured the essence of what Gadamer describes as "the fundamental openness of experience to new experience" (1960/1989, p. 351) she fails to take Gadamer's caution seriously that such experience is perhaps paradoxically "ultimately incomprehensible" and yet acquired "not without preparation" (p. 352). Such a paradoxical state arises from Gadamer's understanding of history and tradition in which he takes hermeneutical experience to be fully situated

> within its own historicity. To be situated within a tradition does not limit the freedom of knowledge but makes it possible (Gadamer, 1960/1989, p. 361).

Thus, when Benner (1984) describes the novice nurse to be one whose behaviour "is extremely limited and inflexible" (p. 21) and that this situation arises from

> the fact that since novices have no experience of the situation they face, they must be given rules to guide their performance (Benner, 1984, p. 21)

the description underlines her failure to understand Gadamer's central point about experience being located within a tradition. Only from within a tradition is the experience understandable to the individual experiencing the event. This point will be developed presently. Opposing the views expressed by Benner, and returning to Gadamer's text on experience to extend the argument, Benner's conception of the experiential event will be turned around to explore the

possibility that it is the novice nurse who experiences in the hermeneutical sense and it is the expert whose behaviour is limited by rules.

3.2 Benner's 'experience' as "knowledge of human nature"

It must first be established how Benner views the relationship between experience and knowledge. What Benner describes through her progressive notion of experience-as-knowledge equates with what Gadamer has described as "knowledge of human nature" (1960/1989, p. 358). In this sense of experience, described by Gadamer as "purely self-regarding" (p. 358),

> we understand the other person in the same way that we understand any other typical event in our experiential field--i.e., he is predictable (Gadamer, 1960/1989, p. 358).

Benner is clearly drawing on this understanding of experience when she outlines the five levels of practice she claims nurses pass through as they develop expertise through experience. Once having achieved the ultimate level of 'expert', equipped with "enormous background of experience" (Benner, 1984, p. 32) this nurse is said by Benner to have "an intuitive grasp of each situation" (1984, p. 32).

Within this orientation, however, lies the central problem of Benner's thesis. The way in which Benner constitutes the effect which language has on the nurse suggests that language corresponds with a reality which is 'out there', rather than language having been drawn on by the nurse to constitute her interactions with others. This represents a misunderstanding of the position which Gadamer advances regarding experience, knowledge and understanding.

3.3 Language: the vehicle for understanding experience

Gadamer (1976) locates his explication of the concept of experience within the metaphor of "play" (p. 53). Understanding is said to be a hermeneutic task which "includes a reflective dimension from the very beginning" (p. 45). Understanding is not merely a reproduction of knowledge: it is "*aware* of the fact that it is indeed an act of repeating" (p. 45). Understanding is hermeneutical as soon as a social actor, through the mechanism of reflection, is aware of

distance between the 'self' and the 'other'. Understanding reflects the ultimate attempt at intersubjectivity through which all approaches to the 'other' are made.

Where Benner's view becomes distorted is in a misconception regarding Heidegger's critique of philosophical idealism, further developed by Gadamer. Returning the concept of time to a central position, Gadamer argues that Heidegger demonstrated the validity of taking a historical stance with regard to understanding. In this, he opposed the position which Wilhelm Dilthey had been foremost in propagating. Linge (1976, p. xiii - xvi) claims that Dilthey's aim was to establish an order of knowledge of the human world which would be as rigourous as that of the natural sciences' knowledge of nature. In order to achieve this, Dilthey suggested that it was necessary to identify the meaning of the text with the subjective intention of the author. This claim effectively negates the temporal distance which separates the contemporary 'self' from the distant past of the 'other'. From Gadamer's perspective this also means a negation of the 'self's' own present as a vital extension of the past. For Dilthey, however, the interpretative task can only be achieved if the 'self' can effectively extricate itself from "the immediate entanglements of history" (Linge, 1976, p. xiv). Gadamer's position is in direct contrast to this aspect of Dilthey's thesis.

Gadamer claims that it was only with Heidegger's critique of philosophical subjectivism in *Being and Time* that the extent to which Dilthey had surrendered to the modern concept of science became apparent. For Heidegger and Gadamer, to understand is not just a matter of "fortuitous sympathy" (Gadamer, 1976, p. 48). Nor is it a matter of setting aside horizons and prejudices to return to an 'original' intent and meaning. Rather, 'understanding' reveals that the historicity of the individual who claims to understand is already at work in the choice of objects, the ordering of those objects, as a problem for understanding.

Gadamer puts forward the position that the real question being addressed in Heidegger's central work, *Being and Time*

> is not in what way being can be understood but in what way understanding *is* being (Gadamer, 1976, p. 49, emphasis in original).

This crucial distinction is not captured in Benner's placement of experience and its role in understanding.

Benner is determined to view 'experience' as understanding clinical situations encountered by the nurse from an idealist perspective. The view from an idealist perspective is that, through experience, the self becomes an "authentic self" (Gadamer, 1976, p. 51). Benner claims that understanding arising from the experience of critical incidents ultimately has an effect on the nurse. That is, understanding is viewed as something which happens to the nurse, adding something to her understanding of future, similar incidents. I use the word 'adding' here not in the incremental sense driving Benner's levels of practice but rather in the sense that understanding has an effect on the 'horizon' from which the individual approaches events. So, rather than adding something to the individual's repertoire of understandings, Gadamer suggests that understanding involves "a loss of self" (p. 51). To explore this, he moves into the metaphor of the game.

3.4 The 'play' of language

Understanding, according to Gadamer, occurs through an exchange of language between individuals who approach events with separate and distinct histories. Any attempt at understanding "should be investigated in terms of the structure of the game" (Gadamer, 1976, p. 51). Gadamer views the coming together of individuals as a contingent event as it requires a certain amount of 'accommodation' to take place during the exchange of speech acts. It is here that the "loss of self" occurs. Understanding can only be achieved if the actors take up positions which accommodate both individuals *as* individuals who can only ever attempt, but never gain, full intersubjectivity.

The accommodated position reflects a state in which

> whatever is brought into play or comes into play no longer depends on itself but is dominated by the relation that we call the game (Gadamer, 1976, p. 53).

The game takes over during the exchange of speech acts and it is through the game that actors can begin to exchange speech in a meaningful way.

Apprehension of some 'reality' which is 'out there', reflected in Benner's view of

experience, is not the outcome of the game. Rather the outcome is what is constituted *between* the actors, which can then be described by them as 'understanding'. This outcome occurs as a result of the game which they construct through the event of coming together, of experiencing one another.

The understanding of an event as an experience, relayed by nurses to Benner, reflects their encounter with patients and other health care professionals from their position as spatially and temporally located social actors. The recollections based in narratives of 'experiences' they have had, will be constituted out of that historical moment, and will reflect all the horizons and prejudices which constitute each individual approaching the event. Any understanding which emerges from the 'play' of language during the event is only possible *because of* these horizons and prejudices.

> For the self-understanding only realizes itself in the understanding of a subject matter and does not have the character of a free self-realization. The self that we are does not possess itself; one could say that it "happens" (Gadamer, 1976, p. 55).

'Reality' then is not a series of historical texts or events which exist as objects for interpretation, but rather describe "the ground the interpreter himself occupies when he understands" (Linge, 1976, p. xv). This ground is constituted through an already ordered system of language. Understanding as experience can only occur *through* language and be reproduced *as* language. The syntactic structure of language, the order of language, is fundamental to the initial accommodation required prior to the beginning of the game.

3.5 Constituting experience through language

This brings the centrality of language in to the argument. Benner's construction of the problem of differentiating expert nurses from novice nurses relies on differences in the description of critical incidents, constituted through language. Benner marks a distinction between expert nurses and all other nurses by claiming that this most clinically advanced nurse has an "intuitive grasp" of the clinical situation. This statement contradicts Giddens' view which is that the intuitive grasp "is the very ontological condition of human life in society as

such" (Giddens, 1976, p. 19). All the nurses studied by Benner have an intuitive grasp. It is the way in which this grasp is made manifest that gives the *appearance* of 'difference'.

Following Heidegger's central thesis that "understanding *is* being", it is impossible to sustain the argument that only one specific group of nurses perceive health care events with an intuitive grasp. Understanding is not a mysterious matter of intuition or empathy with the 'other', but rather a semantic, syntactic and pragmatic matter. The reflexivity implicitly involved in the construction of reality "is intimately and integrally dependent upon the social character of language" (Giddens, 1976, p. 20). 'Experience', as far as it can be described, is only that which is constituted through the 'game', structured by language. Only by virtue of structures inherent to language can we say that we 'know'.

3.6 The constitution of experiential patterns

Benner's central claim is that experience, and the ability of the nurse to apply experience to patient care situations, forms the basis of the nurse's expertise. This represents a 'static' view of experience in nursing practice. It must be recognized that the constitution of 'patterns' recognized by expert nurses, upon which they claim to base future actions, is a result of an 'ordering' process itself. The formulation of 'pattern' suggests a sense of static stability, common to functionalist perspectives. This represents a failure to 'locate' the interaction from which the pattern emerges in a temporal context (Giddens, 1979, p. 202). Benner's experts describe their paradigm cases in the form of a 'snapshot' suggesting the totality of some patterned understanding of an experience of patient care. This pattern is then said to inform future contacts with patients. Benner claims that the patterns consist of "configurations and relationships" (Benner & Tanner, 1987, p. 24), "learned" and thus "recognized" by the expert nurse. Having 'seen' this before, the nurse is said to 'know' how to respond. The constitution of 'expertise' on these grounds have been addressed by Latour (1987) and Law (1986) and will be explored further in chapter seven.

Giddens claims that such a

> snapshot would not reveal a pattern at all, because *any patterns of interaction that exist are situated in time*; only when examined over time do they form 'patterns' at all (Giddens, 1979, p. 202, emphasis in original).

This conception of pattern is paradoxical. Recognizing a pattern suggests stability. And yet if, as Giddens suggests, patterns can only be formed over time, there is a sense in which these patterns are constantly changing. No two situations can possibly be 'alike' in the sense which Benner describes because they occur in different temporal and spatial locations. What I am suggesting is that nurses who claim to recognize "patterns" are responding to a wider social knowledgeability which Benner's construction of experience is too limited to account for.

What does appear to take place through Benner's act of interpreting the paradigm cases relayed by nurses, is the *construction* of stability and patterns. Such construction is facilitated by orders constituted through language. It will be argued in the following section that, rather than recognizing patterns of patient behaviour, based on some fundamental knowledge, nurses constitute 'patterns' through language. This constitution is taken by Benner to imply the demonstration of 'expertise' by nurses. However, Benner's perspective fails to appreciate the constituting nature of language. This naive view does not account for the way in which power is implicated in the constitution of knowledge.

3.7 Language and expertise

In a recent publication, Benner and her colleagues (Benner, Tanner & Chesla, 1992) use Benner's original categories of novice to expert to describe how, through 'experience', the nurse comes to "differentiate" the clinical world in which they work. Contradicting earlier statements that experience is not linked with "mere passage of time or longevity" (Benner, 1984, p. 36), preparation for this study involved the segregation of their sample of 105 nurses into three groups: the advanced beginner group were represented by nurses who had worked in the clinical setting for up to six months; the intermediate group had worked in the setting for up to two years; and to be allocated to the expert group, the nurse must have worked in the setting for at least five years (Benner et at., 1992, p. 15).

This represents an example of pre-ordering. By not allowing categories to arise from the data itself, Benner rejects the possibility of falsifying her earlier theoretical suppositions (Popper, 1972, p. 228). By using longevity of service to pre-order her sample of nurses into the advanced beginner, intermediate and expert categories, Benner rejects the possibility of strengthening her theoretical formulations about expertise by attempting to clarify the nature and type of experience which relates to expertise. Instead, this approach to data collection demonstrates a concern with merely reproducing the basic theoretical position.

Nurses from each group were asked to "tell a story" (Benner et al., 1992, p. 15) about their practice. Two examples from the data will be presented to further the discussion. The first example was given by a nurse from the advanced beginner group:

> I think the one thing I felt improved was just watching how a child in respiratory distress copes. This child was coping, and every sign or symptom that I'd ever learned in school I was seeing before me. His little face was puffed out to here, and his little arms were going a mile a minute, and his nares were flaring, and he had retractions practically through the other side (Benner et al., 1992, p. 17).

This story contrasts significantly from one provided by a nurse from the expert group. The nurse in the next 'story' is relating a patient care situation in which she made an intervention. The nurse claims that on the basis of her interpretation of the situational context, she decided to enter the room to speak with the nurse and medical student who were already in attendance with the patient:

> I had a sense of what was going on and I looked at the patient and there were two things that I noticed right off: one that her abdomen was very large and very firm and the other that her knees were mottled. I said, "she has a dead bowel". And they said, "She doesn't have a dead bowel". And I said, "She has a dead bowel". All right, trying to back off a little bit, I asked "Would we consider that maybe she has an ischemic bowel?" (Benner et al., 1992, p. 25).

What is the basis of the difference between these two 'stories'? Benner would have it that the difference lies in the differentiated experience of the nurses which permits the expert nurse to perceive the clinical situation

differently than the advanced beginner. The advanced beginner is characterized as being able to identify "aspects of the situation" (Benner, 1984, p. 22). As the excerpt from the first story suggests, the advanced beginner recognizes those signs of respiratory distress which correspond to signs she was taught during a period of training. According to Benner, the expert nurse is no longer concerned with making correspondences between rules learned in school and clinical situations. The expert nurse,

> with an enormous background of experience, now has an intuitive grasp of each situation and zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions (Benner, 1984, p. 32).

This appears to 'fit' with the 'story' told in the second example above.

However, the fit of these two examples is suspect if we take the accounts as corresponding with events: in the first excerpt, the nurse describes the 'fit' between her observations of a child with a defined medical diagnosis and her expectations based on information she recalls from school. The nurse describes how "every sign or symptom" mentioned in the de-contextualized world of the classroom, was placed into context for her with this particular 'experience'. The nurse links this 'fit' between what was learned at school and what was seen in the clinical setting with a perceived improvement in her self, as a nurse. What had previously been words on a page (or a blackboard) were now transformed by a visual event, confirming for the nurse both the 'knowledge' learned in the classroom and the accuracy of her perceptions of the clinical event.

This situation is re-examined using Gadamer's concept of "play". The relationship now pertaining for the nurse between the account of information transmitted in the classroom with that of the particular clinical event described has "happened" (Gadamer, 1976, p. 55) because of the loss of the nurse as 'self' into her understanding of the experience of the child's distress. This understanding is prejudiced by her recollection of the information presented in the classroom (as well as any previous event of children, breathing difficulties etc.), which she brings to the event as a part of her horizon of understanding; that is, as a part of her self.

In contrast to this example, the situation reported by the "expert" nurse accounts for a different form of understanding. The nurse's language demonstrates a firm knowledge of "what was going on". She reports the two things she "noticed right off" very concisely, as though making a report to on-coming staff. What becomes the 'point' of the story however, is not merely that she "notices" the symptoms and signs as was the 'point' to the beginner's story. The 'point' of the second story is that the nurse was 'more knowledgeable' than either of the two health professionals attending to the patient.

The nurse uses language in the telling of her story to describe "positions" (Giddens, 1984; see also Lyotard, 1976 / 1984) taken by actors involved in the situation. Lacking an observational cross-check on the event as told by the nurse, Benner relies solely on the constructed account itself. Benner's 'understanding' of this story is informed by shared 'stocks of knowledge', which she derives as a member of the social world which the nurse is describing. As such, her understanding is informed through mechanisms described as "the world known in common and taken for granted" (Garfinkel, 1967, p. 37). Benner interprets the nurse's story by drawing on unquestioned assumptions regarding the nature of the moral order upon which the story is based. The saliency of the story relies on the reader having to assume the same moral order informing actors in the situation regarding what could be expected and assumed as shared knowledge by all other social actors approaching the situation with similar background experience.

Lacking the observational cross-check, however, Benner's interpretation of the events relayed by the nurse, demonstrates a post-hoc rationalization rather than a critical account of practice. The nurse's story stands as a one-dimensional account of a complex social interaction. Drawing from her own discursive and practical consciousness, Benner's interpretation of the account reproduces the moral order that she assumes would inform any other 'experienced' nurse to interpret the account in the same way.

3.8 The location of power in Benner's analysis: language as a 'prop'

The story told by the 'experienced' nurse demonstrates a theme frequently found in Benner's work as indicative of expert nurses. Benner accounts for leaving the "stories" in "the same 'spoken' language" (1984, p. 207) because she does not want to

> strip away the evidence of concern and advocacy for the patient expressed in the telling of these stories (1984, p. 207).

The basis of her "evidence" however, is questionable. Describing the stories as "narratives", Benner and her colleagues claim that an underlying theme is that the expert has "a different and better grasp of a situation than other clinicians" (Benner et al., 1992, p. 25). A critique of the "evidence" demonstrates that the basis of this claim is highly questionable.

It seems clear that the nurse, as part of telling her "story" will recall events in which she could be seen to demonstrate her "skills" to the best advantage. This in and of itself is not problematic. However, what must be guarded against is equating the nurse's story with an empirical reality, a reality which is 'out there'. Benner's writing suggests that she accepts without question the nurses paradigm cases as representations of a normatively agreed upon reality.

It is precisely that reality which is brought into question in this thesis. Rather than accepting the accounts as representative of an unquestioned reality, I would argue that the accounts are particularly important in terms of what they offer as empirical evidence of the methods used by nurse's to constitute their work. The nurses' accounts demonstrate the way in which they 'prop up' existing power relationships through discursive strategies.

In the work situation, the nurse is involved in a hierarchical arrangement, positioned between doctors and patients (Dingwall, Rafferty & Webster, 1988; Melia, 1984) in the organization. This 'position' influences the constitution of the experience (Giddens, 1984; Lyotard, 1979/1984). As the examples from Benner's work demonstrate, nurses draw on this structural feature of work to attribute meaning to their work experiences. Also demonstrated in the "narrative" is the reproduction of the hierarchical position by social actors involved in the event. The language used to describe the event

instantiates relationships as they are constituted through interaction among actors. Benner naively reproduces the relationships by ignoring the influence of power on their construction.

For example, the story told by the 'expert' practitioner describes a nurse, constituted in the story as being knowledgeable about the signs and symptoms displayed by the patient. Her 'story' is constructed as an oppositional tale; reflecting and reproducing her place in the organization as able to perceive the symptoms yet not in a position to have the 'label' she arrives at legitimated by other practitioners. The statement made by the expert nurse to the nurse and the medical student was not only conveying meaning in terms of signification (Giddens, 1984, p. 31). The message, encoded within an organizational frame of reference, results in an interlacing of meaning with normative elements (moral order) and power. The example is one of a structurated process (Giddens, 1984).

The nurse encodes a message which is decoded within context-dependent frames of signification, legitimation and domination by the nurse and doctor engaged in 'caring' for the patient. As someone who could be described as merely an 'interested bystander' and who, by her intrusion, is questioning the competence of the other actors, such comments are portrayed in the nurse's account as being not valued in that particular work setting. The expert nurse legitimates her intrusion as an attempt to assist a colleague whose behaviour was described as demonstrating a "desperate need for help" (Benner et al., 1992, p. 25). Describing the alteration of her initial claim to have her presence viewed legitimately as "backing off a little bit", the nurse reproduces the power inherent to the hierarchical structure within which the interaction is being constituted. She characterizes herself as having 'over-stepped' a boundary, instantiated by members in the work setting. Recognition of the existence of the boundary is reproduced in the nurse's rendering of the story as having to "back off".

3.9 The importance of cross-checks on the analysis of power

Benner acknowledges some theoretical notion of power which she claims is illustrated through the "evidence of concern and advocacy" (Benner, 1984, p. 207) expressed by nurses in the accounts of "critical incidents" (1984, p. 300).

Benner's aim, however, is to shift the notion of power from one heirarchical arrangement to another. Benner claims that nurses have been "mistaken" to view themselves as powerless within the "male-dominated hospital hierarchy"(1984, p. 207). She states that accounts given by nurses provide "glimpses of the nature of the power that resides in caring" (p. 209). Benner frames the study as one of empowering nurses by urging them to value caring as their unique source of power. The risk is that empowered nurses are characterized as acting under the authority of the patient. With no cross-checks available, the patient's voice is dangerously absent.

"Concern" and "advocacy" are de-contextualized, despite Benner's acknowledgement that the nurse-patient "relationship is highly contextual" (p. 209). The de-contextualization occurs because Benner does not provide observational cross-checks on these concepts. Benner claims that "'experienced nurses' were observed in addition to being interviewed" (1984, p. 16) as part of her research methods. Yet, what remains unclear in the face of this description of the research techniques used to generate data for the study documented in 1984 or from subsequent descriptions is whether the 'observations' of expert nurses coincided with stories told by the nurses during interviews. Certainly Benner makes no attempt to cross-check these data sources during her discussion of the data.

Her use of "paired interviews" (1984, p. 14) suggests a further opportunity missed to cross-check the nurses accounts of the same event. Rather than using the paired interviews to cross-check the accounts made, Benner's use of the multiple sources of data (paired interviews, individual interviews, observations) act merely to offer more data as "evidence", not a critical examination of the data itself. There is no evidence of triangulation of the data (cf. Denzin, 1970, Duffy, 1987b).

Devoid of any attempt to theorize the way in which verbal accounts evolve from structurated social encounters, Benner's work fails to provide more than a one-sided version of clinical events through the nurses account of "paradigm cases" (1984, p. 8). Revealing only the nurses' accounts of action, and lacking the observational cross-check of the event described by the nurse, the

"evidence" provided of 'progress' by nurses from novice to expert is not as conclusive as Benner suggests. This 'evidence' can be investigated more fruitfully as constitutional of nursing practice.

3.10 Knowledge, context and experience: the significance of power

It is proposed in this thesis that rather than being *indicative* of differences in levels of expertise and progress through levels over time, the narratives represent *artifacts* of the constitutional basis of nursing work. Benner has attempted a theoretical formulation of practice which rests on a simplistic notion of the concept of time and its place in social change.

Writing extensively over the past ten years, Benner has relied almost entirely on interview material to present her theoretical formulations regarding nursing practice (Benner, 1982; 1983; 1984; 1985; 1991; Benner and Tanner, 1987; Benner & Wrubel, 1989; Benner, Tanner & Chesla, 1992). This has had the effect of de-contextualizing her accounts of practice. A misplaced concern to link expert practice with experience gained over time has resulted in the significance of Gadamer's writings on the conditions which make experience possible to be disregarded in Benner's work.

For example, Benner and Tanner (1987) relate an account of what they label "pattern recognition" (p. 24). Recalling events surrounding the treatment of a patient described as having "a lot of cerebral edema", the nurse states,

> Even though I wasn't taking care of him that night, I wanted to investigate. I had a suspicion that there was something wrong with him and maybe that's sort of an inside thing. I walked in to help the patient ... He was sort of pale and anxious. He had all the classic signs of a pulmonary embolus. He was still conscious. We called the doctor, and then he coded (Benner & Tanner, 1987, p. 24).

The heroic nature of the nurse's work is constructed through careful attention to detail, cool delivery, and minimal fuss demonstrated at the outcome. The nurse responds to her "suspicion" by entering the room, "even though" she was not assigned to care for the patient during the shift. This points to a sense of 'dedication' included as a part of her 'story'. The nurse recalls specific "classic signs" which she labels and which, according to the account, provide the

direction for her actions. She notifies the physician in charge of the patient's case. She states, "and then he coded". The rhythmic flow of the account suggests a calm, orderly progression of events, including the events following the realization that the patient was in need of cardio-vascular resuscitation. Information regarding the spatial and temporal features of the account is 'lost' because there is no observational 'cross-check' on the nurse's account.

The lack of observational cross-checks place limitations on the claims made by Benner. Benner's accounts of practice are used to privilege the nurse's recollections of an event in an attempt to reveal aspects of knowledge, claimed to have had insufficient attention in nursing research over the years. She therefore privileges transcription of verbal reports over a temporal and spatial account of action, in the process ignoring crucial aspects of how language operates in the construction of a 'critical incident'. The necessity of taking a critical approach to the constitution of organized practices such as those conducted by nurses is required in order to extend the work signalled by Benner's attention to the field of practice.

4.0 In consideration of temporality and power

This chapter has focussed critical attention on the work of two researchers whose efforts stand as important examples of investigations into nursing practice. The great benefit of this work has been to return attention to what has become a neglected topic in research, that is the practice of nursing. However, through critical reflection on this work it has been possible to illuminate some of the underlying problems and implications of such approaches to nursing research.

Field's landmark study of community nursing practice has been criticized on two fronts. First, the way in which agency is conceptualized was demonstrated to limit accounts of the knowledgeability demonstrated by nurses as competent social actors. Observation of the nurses' practice and changes in practice noticed over the period of data collection were reported but then 'marginalized' because the theoretical framework, derived from a functionalist perspective, was concerned only with verbal accounts of that practice. This had

the effect of placing the researcher in a position to group observed practices together and then press them into pre-existing normative descriptions of practice.

Second, in an attempt to 'rationalize' the differences in practice observed during fieldwork, Field deferred to Benner's categories of clinical expertise. Benner's notion of experience was criticized for being based on a misconception regarding the constitutive nature of language in understandings of experience. Rather than being indicative of specific alterations in practice as Benner's writing suggests, the claim advanced in this chapter was that differences in accounts of practice represent discursive artifacts of an altered knowledgeability of the work setting on the part of the nurse. Benner's treatment of accounts suggests that 'change' happens internally; that is the nurse's cognitive abilities change based on clinical experiences.

In contrast, the position put forward in this thesis was that changes such as those identified by Benner demonstrate a different form of accounting for the work setting. The form of accounting derives from altered readings made by knowledgeable social actors of the social context in which nursing is practiced. The crucial point raised was that those readings which inform the nurse's understanding of the clinical setting are the same ones upon which she makes further readings. Thus, her understanding of practice 'changes' but this should not be seen as being in any way comparable to progress in terms of some ideal sense of practice. Change-as-progress, described by Benner as "evidence" of increasing expertise, is contrasted within the context of this thesis as an artifact of the data, mediated by language.

The 'order' framing Benner's development of levels of nursing expertise have been subjected to examination. That is, what lay anterior to the reported 'experiences' by nurses was examined in an attempt to determine the conditions surrounding the use of these words, and their constitutional effect on the form of 'experience' reported. An understanding of language as interpenetrated by power has been excluded in Benner's analysis. Language used by the nurses who gave accounts of practice illustrated a reproduction in existing power relations. By not acknowledging the effect which language has in 'propping up' power relations in

the constitution of social reality, Benner's analysis makes naive assertions regarding 'progress' towards expert practice.

It is concluded then that both Benner's and Field's reports are incomplete because they inadequately theorize notions of power and moral regulation within verbal accounts of practice. Field's work brings these concepts in, only to marginalize them, as she privileges the nurses' verbal accounts of practice. Field uses her observation of that practice to merely support the account given by the nurse. Benner's de-contextualized accounts of practice were criticized for not making use of triangulated data sources to cross-check the accounts given by nurses.

This chapter has demonstrated the effects that inadequate treatment of power and language has on the outcome of research into practice as social action. It has been suggested that methodologies which take the constitution of experience through language as central to an investigation of nursing practice are in a better position to offer illuminating descriptions of practice and explanations of the conditions which constitute practice. However, it must be reiterated that experiences of practice as constituted through language represent complex social accomplishments involving not merely the production of meaning but also the effects of power relations.

A close and critical reading of how social processes 'work' within practice settings has excavated the extent to which power interpenetrates practice. Such an approach presupposes a radical re-examination of the temporality of practice. In this chapter, the critique of Benner's work demonstrated the instability of a simplistic notion of 'progress' in practice. Arising from such simplistic notions are the all-too-common calls for re-training. Without sufficient attention to the place of power in language, the risk is that nurses will merely generate alternative strategies for accounting for action. Re-training strategies may only further alienate nurses from the experience of patients who enter the practice setting in search of some form of 'nursing care'.

In the following chapter the relationship between the researcher and the field is explored. By foregrounding the concepts of experience, time, power and language which have emerged from this critique of practice-based research, the

aim is to identify methods which can generate an account of practice. Crucially, the methods will be investigated in terms of their validity in relation to the field of practice as a socially constructed location of strategic action.

CHAPTER FOUR

Representations of Action:

re-orienting field studies

> The young man's sarcastic reserve suited the girl very well--it freed her from herself. For she herself was, above all, the epitome of jealousy. The moment she stopped seeing the gallantly seductive young man beside her and saw only his inaccessible face, her jealously subsided. The girl could forget herself and give herself up to her role.
>
> Her role? What was her role? It was a role out of trashy literature. The hitchhiker stopped the car not to get a ride, but to seduce the man who was driving the car. She was an artful seductress, cleverly knowing how to use her charms. The girl slipped into this silly, romantic part with an ease that astonished her and held her spellbound.
>
> M. Kundera, The Hitchhiking Game (p. 10)

1.0 Introduction

In the last two chapters my aim has been first to suggest and then to demonstrate how a sufficiently sophisticated conception of both power and 'the social' have been systematically excluded from current theorizing about the practice of nursing. In the last chapter, two important pieces of research conducted in the field of practice were examined critically. In both Field's study of community nursing practice and Benner's study of acute care practice, power and 'the social' were demonstrated to be present, that is, impossible to efface, yet not incorporated in a systematic way in accounts of nursing practice emerging from the respective studies. Lacking a substantial theory of power and its effects

on social action these central features of a practice discipline such as nursing were demonstrated to have been treated as marginal, held outside of the discussion.

In this chapter, a wider examination of the nature of field studies as they are presently conceptualized within the health care literature will be undertaken. The aim of the chapter is to demonstrate the limitations inherent in much of the research claiming to arise from field studies in order to clear a site for the study undertaken to illustrate the present thesis.

In the last chapter, it was argued that conceptualizations of action represent a central challenge for nursing research. The way in which action is conceptualized influences not only the type of research engaged in but also the very approach to the field of study. For example Melia (1982) stated over a decade ago that

> there is an implicit, if not explicit, pressure put upon researchers in nursing to provide answers which can form the basis of action (1982, p. 328).

Melia suggests that actions engaged in by nurses are informed by knowledge produced by researchers. As a researcher, Melia's statement reflects a move made from a position of socially constructed responsibility to produce answers for practice questions. Like the hitchhiker in Kundera's intricate tale of 'misrepresentation', the notion of 'role' will be critically explored, in particular, the 'role' of the researcher, positioned in a particular relation to 'the field'.

I will argue in this chapter that the "pressure" referred to by Melia represents an effect of trends influencing the production of nursing research in 1982, trends which continue to influence nursing research today. Rather than pressure being exerted on researchers by practitioners as Melia's statement suggests, I would argue that researchers have incorporated the concept of 'pressure' into their accounts of practice as a mechanism for legitimating their efforts as a 'need' for research to inform practice. As I will demonstrate, these manoeuvres have important implications for the ensuing relationship between the researcher and the field.

In this chapter, the relationship between field studies, the performance of nursing as an 'action' and the accomplishment of socially recognized practices

called 'nursing' will be addressed. Of central concern is answering the question of how to approach and conceptualize what it is that members do in order to represent that action in ways which can be taken as valid representations of action. A re-orientation of field studies can be accomplished through critically examining the relationship between the researcher and the field. Present ethnographic studies, conducted under the auspices of informing nursing practice will be examined in an effort to determine where the researcher locates him or herself with regard to the site of practice. This will be contrasted with the goals of the present study which, particularly apposite for this chapter, seeks to explicate how knowledge of what facilitates *action* is implicated in the constitution of practice.

2.0 Ethnographic studies of nursing practice

Nursing research has reached the point where it is ceasing to be apologetic for using qualitative methods to answer its questions. The move to qualitative studies has a long but perhaps not entirely impressive history in nursing research. A reading of qualitative studies (for instance those reported in Leininger, 1985; Field & Morse, 1985; Munhall & Oiler, 1986; Morse, 1991b; Morse & Johnson, 1991) immediately suggests two major points which continue to plague the interpretative tradition within nursing studies. First is the purpose for which such research is undertaken. Tied up with the problematics of 'purpose' but treated separately in the literature is how the researcher can relate to the field of study. While receiving increasing publicity but little critical debate, these problems can be taken together by asking the question: Upon what 'terms' will the researcher relate him or herself to the field? This question will be explored in the following sections.

2.1 The problem of 'purpose'

Field studies of nursing practice have tended, for the most part, to be descriptive in nature. The following 'rationalization' for conducting field studies represents a common theme in the literature. Field studies in nursing practice are frequently legitimated by having as their purpose, the "discovery" of

> new information about clients in various situations: The more nurses know about their clients and families and how they experience situations, the better able they will be to care for them (Boyle, 1991, p. 277).

The image is one of unknown waters, uncharted territory. The practice of nursing is not questioned. Rather, nursing is characterized as actions aimed at discrete 'problems', few of which have yet been explored by researchers in order to make them available as clear targets for practicing nurses to engage with.

The problems associated with such an approach to the field can best be illustrated with reference to a particular study. Drawing on the example of a collaborative project conducted under the auspices of a 'field study', Boyle (1991) describes the "steps" (p. 278) involved in setting the study up. As a collaborative project, the study involved seeking input from a variety of sources including 'practitioners', 'educators', and 'students'. The aim of this (primarily) educational experience focused on "solving clinical problems encountered in community health nursing practice" (p. 278). In line with the educational model informing the study, the 'practitioners' formulated the problem, the 'educators' conceptualized it as a research project, and the 'students' carried out the fieldwork. In so doing, the research process is subordinated to the educational process, firmly announcing the field of interest as the educational institution not, as Boyle implies, the practice setting.

A group of community health nurses were asked "what kind of clients were 'difficult'" (Boyle, 1991, p. 278) in their practice setting. The population identified as problematic were pregnant teenagers. Teenage pregnancy was formulated by the community health nurses as a problem by drawing on an economic metaphor to constitute the problem as one of "costs". Nurses claimed that "costs" to the teenager's family and society at large legitimated teenage pregnancy as a problem because of the propensity of this group to have 'high-risk' pregnancies.

Unfortunately, having identified this 'problem' within a field of practice, the researchers then turned their gaze towards the life-world of "key informants" (p. 280), that is, teenagers who were or had been pregnant. The researchers only returned to the 'site' of the problem, the nurses working at the community

health clinic, at a later date. The researchers were now armed with 'knowledge', packaged as the results of their field study into teenage pregnancy. This fulfils the remit of ethnography as proposed earlier by Boyle which was to ascertain "new information about clients in various situations" (p. 277).

I would argue that this represents a failure to understand the nature of 'the ethnographic field'. The field is, after all, the situated context within which 'pregnant teenagers' come to be constituted as 'problematic' subjects for nursing care. Having started out on the right foot, Boyle and her associates quickly make a wrong turn as soon as they leave the field behind in search of 'knowledge for better practice', particularly as this 'knowledge' is taken as though it arises in a location entirely apart from practice.

Boyle's account of the 'purpose' of the field study was framed with a reference to the "experience" of clients and families. Boyle suggests that the object of research should be to define how people "experience situations" in order that nurses can improve their 'care' of these people. As a second, widely observed 'trend' which authors claim to address in 'field studies', "experience", as it is treated by Boyle, is more in line with studies of a phenomenological concern. Studies which point to an interest in the experiences of women undergoing hysterectomy (Chassé, 1991), the experience of husbands whose wives are receiving chemotherapy (Wilson, 1991), the child's view of care during chemo-therapy (Aamodt, 1991), and women's experiences of 'inner strength' (Rose, 1990), relying exclusively on interview material, clearly point to the individual as a site of interest for the researcher. Locating the research problem within the subjective experience of respondents is accompanied by the substantial problems of 'accessing' understanding via accounts given to the researcher addressed in the previous chapter. Such problems are endemic to the phenomenological project and are not lessened by researchers who examine these accounts without the advantage of a critical position. As Porter (1993) has recently argued, all too frequently nurse researchers take an unnecessarily naive position with regard to accounts from research participants. Relying solely on 'reasons' given by research respondents for understandings regarding

'experience' there are significant difficulties to be overcome in substantiating these 'findings' empirically.

The position adopted in this thesis is that the 'problem' of empirical substantiation arises through the production of accounts by researchers seeking to attribute knowledge, understanding and action in the absence of observational cross-checks. If subjectively generated accounts are treated as knowledgeable action in their own right (Garfinkel, 1967; Giddens, 1984), and if actor's accounts represent only one aspect of a triangulated account of action (Denzin, 1970), then such accounts are no longer problematic in the same way they are in phenomenological studies. Accounts of action, provided by individuals participating in practice relationships can be triangulated with observational accounts generated by the researcher. Field studies are strengthened in this way because the possibility exists to apply critical methods to an analysis of research materials. The importance of considering the relationship between the researcher and 'the field' is raised again to the extent that the researcher is made 'present' in this relation by playing the central part in formulating interpretations and representations made about 'the field'.

2.2 The effort to validate 'knowledge' outside the practice relationship

In advocating a move away from the site of the practice relationship where 'difficulties' are constituted, Boyle demonstrates an unacknowledged view of nursing practice as an objective reality. For Boyle, nursing lacks only a sufficiently detailed knowledge base upon which practice can be objectively applied with predictable results. As such, she seeks to legitimate knowledge about nursing practice outside of the context from which it is constituted as a reality. To reiterate the position taken in this thesis, reality is understood as constituted *within* social relations occurring amongst members in specifiable contexts.

The failure to acknowledge the social construction of institutionalized actions such as nursing goes some way towards explaining the exhaustive lengths entered into by researchers to address the concept of validity in qualitative research. The over-riding concern with identifying the many and varied ways in

which qualitative research results are equally as valid as those achieved through quantitative means reflects the remnants of an apologia for qualitative designs. More so, however, it reflects the nascent state of debate regarding the relationship between the researcher and the field.

As was demonstrated above, the focus of much, so-called ethnographic research, has been on the development of 'knowledge for practice'. There has been a concern with obtaining representative samples (Field, 1983; Morse, 1991c) and with the influence of the researcher on the population under study (Bergum, 1991; Brink, 1991; Lipson, 1991).

Concerned with being able to specify "units of analysis" for ethnographic research, Aamodt (1991) claimed that she defines a "unit" as linguistic expressions which have

> 'made it' in the written and oral communication systems of nursing (p. 48).

However, this is to suggest that viability of language expressions takes precedence over their situated meaning, again attending to the emphasis on practice as 'objective reality'.

Researchers are advised to "get close" (Boyle, 1991, p. 276) to the identified study population. Getting close involves studying the population and analyzing results within the "natural setting" (Boyle, 1991, p. 276). When treated in this way, the field takes on near magical properties where the field, and not the researcher, is taken as inducing more valid and reliable results. The researcher is treated as though additional to the process engaged in: consideration is given only to maximizing his or her relationship with the field.

Methods advocated to maximize this relationship are addressed by Brink (1991). She suggests that security of interpretation can be maximized by seeking the 'expert' assistance of a "judge panel" (p. 171) when making decisions about key informants. Interpretation is also said to be secured with the "longitudinal nature" (p. 171) of ethnographic studies. This is to suggest that if the advice of the experts is followed and a specified period of time is spent in 'the field', valid results will ensue. The concern underpinning such a view is, however, with securing valid interpretations by drawing on supportive structures located

external to the field. As such it fails to come to grips with the central issue of interpretation.

Brink's advice for increasing validity can be taken simply as an attempt to 'remedy' that which is central and is the only legitimate basis for validation within the ethnographic project: the reflexive relationship between the researcher and the field. Brink exemplifies and reproduces the very suspicions which have marginalized interpretive studies in nursing to date. For how can the question of 'how much is enough?' be answered outside of the context of a particular field study? Will two interviews be enough or are fifty required? Will two years of observation necessarily lead to greater security upon which interpretations are made than six months observation? 'Remedial' answers to such questions introduce more problems rather than allaying concerns regarding the nature of interpretative studies.

3.0 Seeking resolution to issues of validity within the field

Setting aside such 'remedial' solutions as naive, the discussion turns now towards exploring the possibilities inherent in research materials derived from a particular 'field' of study. Issues of validity will be addressed from *within* the interpretative paradigm rather than offering 'remedies' arising from and attending to discourses of other, incommensurable paradigms. The question raised is simply 'How can nursing be represented'? Or perhaps, 'Upon what terms can a study of nurs*ing*, as an action constituted by means of quite diverse social mechanisms, proceed?'

3.1 Talk as an 'outcome' of nursing practice

What has been missed in current theorizing about nursing practice is an adequate account of how nursing is constructed as a social 'reality'. Therefore, the question regarding the terms upon which such a study might proceed must be framed for the purposes of the present thesis in such a way that takes account of how members engaged in interaction construct nursing through social mechanisms.

The notion of power is implicit. 'Nursing' does not 'just happen'. Nursing actions can be located within specifiable contextual boundaries. Drawing on Giddens' concept of the duality of structure, the position taken in this thesis is that 'nursing' is constituted by knowledgeable members who draw on "the structural properties of social systems (taken to be) both medium and outcome of the practices they recursively organize" (Giddens, 1984, p. 25). This conceptualization suggests that day-to-day encounters in practice settings can be examined to excavate local meanings held by members regarding their understanding of nursing actions. The question addresses the practicalities of conducting research in order that these meanings can be 'excavated'.

Language is clearly central to such an understanding of the constitution of nursing practice. Benner's (1984) work signals a new and promising shift in nursing research to investigate this aspect of practice but, as demonstrated in the preceding chapter, is deeply problematic in its treatment of action.

Wolf (1988, 1989) has examined ritual aspects of language in nursing practice such as those used by nurses while caring for the deceased and in change of shift reports. Seeking merely to make these rituals 'visible' however, Wolf fails to push her interpretation far enough to examine how these rituals constitute action and effect the conduct of nurses and patients in their respective positions within institutions of care.

Two recent studies have sought to extend present understandings of the relation between language and practice. Tilley (1990) and May (1991, 1992a, 1992b, 1993) point to more robust methods for exploring what can be said about nursing practice. These studies will be examined in more detail.

Taking psychiatric admission wards as the field, Tilley's concern was to understand the process of reality negotiation operating between nurses and patients. All patients included in the study had been diagnosed as neurotic and were hospitalized for treatment. Tilley's study exemplifies a much more critical stance towards accounts generated from nurses and patients than that typically demonstrated in descriptive accounts of nursing work. Taking a critical position towards the field, Tilley identifies "topics and resources for the work of understanding each other" (p. 315). Practice is understood by Tilley as being

accomplished through the use of everyday 'resources', constructed in particular ways which constitute action recognizable as 'nursing' and 'patient' actions.

Tilley's interpretations of the work of psychiatric nurses and patients to negotiate the 'reality' is based on what he describes as "second order accounts" (p. 316), interpretations of events not directly observed by the researcher. In this way, Tilley incorporates distance into the analytic project. The ensuing relationship between research and the field has important implications on the treatment of power in Tilley's study. While frequently acknowledging the influence of power in the constitution of reality as part of the research framework, Tilley demonstrates a reluctance to suggest how and in what ways the exercise of power conditions the constitution of practice. The nurse and patient individually were asked to account for the encounter. In terms of the position advanced regarding 'experience' in this thesis, the encounters Tilley seeks accounts of represent 'experiences' which have been incorporated into the 'horizon of understandings' (Gadamer, 1976). The account arises from the new horizon of understanding. Tilley's decision not to directly observe interactions, therefore, necessarily impinges on his ability to comment fully on the experiences which are subsequently accounted for in his interviews with the respondents of the study.

Tilley is concerned to demonstrate that methods used to gather research materials could themselves be put to beneficial use to improve practice. He suggests that giving nurses the opportunity to "produce accounts in which they took their own work as a topic for further explanation" (p. 324) may contribute in a significant way to the development of understandings about their practice. A conceptual link is suggested between Tilley's work and that of Patricia Benner. Both claim that in the process of providing accounts of encounters with patients, the experience of that encounter can be shared to illuminate how practice is accomplished. The implication is that not only does the nurse giving the account 'understand' practice more fully but that others who hear the account will also, it is suggested, understand practice more fully because the account has been made available: it has been 'present-ed'.

Noting an "unwillingness to bring 'self' more into practice" (p. 325) by the nurses whose accounts were sought for the study, Tilley suggests that through the process of "talk" this situation might be rectified. Significantly, this special form of talk is to be

> conducted outside the current framework of accountability (Tilley, 1990, p. 325).

By encouraging 'talk' among nursing staff, Tilley suggests that the knowledge generated in the practice relationship might be clarified and the the power relations operating within the relationship might be recognized. The implication of this process is that nurses would cease to employ power in their relations with patients. Such a position has been criticized by Foucault (1984) and Lyotard (1979/1984). The assumptions supporting Tilley's recommendations must therefore be questioned.

Specifically I would question the possibility that the sort of understanding work Tilley refers to *could* take place "outside the current framework of accountability". While accounts and forms of accountability might change depending on the individual charged with drawing these accounts out from staff, to assume that one could step outside present accountability structures is to inadequately theorize the process of accountability. The position advanced by Tilley does not acknowledge fully the interpenetration of accountability by structures of domination, legitimation and signification (Giddens, 1984; Munro, 1991b). Tilley's recommendations for 'stepping outside' suggests that the slate could be wiped clean. However, this would leave nurses with no space within which to formulate accounts of practice. They would be unable to make their accounts of practice count.

Accountability structures are deeply embedded in the methods individuals employ for 'going on' in day-to-day encounters (Giddens, 1984). It is neither desirable nor possible for such structures be set aside. Rather, it is from the embeddedness of accountability structures that members achieve the space for 'authoring' accounts. Drawing on forms of accountability, largely taken-for-granted in organized practice settings, members gain facilities for 'authorizing' accounts of practice. This is to suggest that, embedded in members' accounts, are

grounds for making claims regarding the validity of interpretations in field studies.

3.2 The 'visibility' of understandings: a restriction on the potential of accounts

May's (1991, 1992a, 1992b, 1993) study can be used as an example of critical analysis of nursing work derived from interview accounts. May investigated the ways that nursing practices act to constitute patients as subjects of care. Drawing on Foucault's historical study of the "clinical gaze" (1963/1973), May advances the "therapeutic gaze" (May 1992a, p. 591) as an extension of the clinical gaze

> formulated to reassemble or reconstitute the patient as a human subject (May, 1992a, p. 591).

May theorizes the nurse-client relationship as encounters made problematic through the application of the 'therapeutic gaze'. The effect of the therapeutic gaze, according to May, is one of "fixing" (p. 591) what is known about an individual patient. It could be argued that this finding, that of "fixing" knowledge about patients, may be an effect of the research method used by May: a method which, like Tilley's, relies only on interview accounts from nurses regarding their encounters with patients. This method, like Tilley's, introduces distance into the relation between researcher and field.

May attributes the notion of the "therapeutic gaze" to Bloor and McIntosh (1990) who gave consideration to the concepts of surveillance and concealment. Noting that surveillance had only emerged as a topic of interest to health care researchers with the availability of Foucault's work, Bloor and McIntosh claim that

> the obverse of surveillance -- concealment -- has been similarly unappreciated as a technique of resistance (p. 159).

Bloor and McIntosh treat the act of surveillance from within the narrow confines of a visual metaphor. Thus, resistance to the intrusion of a health visitor during a home visit is investigated by Bloor and McIntosh in terms of client concealment as a technique for resisting the health visitor's inquiries into child care.

Such a perspective on surveillance is more narrow than that envisaged by Foucault. For instance, in an interview he commented that the 'optical' system of surveillance, epitomized by Bentham's design for the Panopticon (cf. Foucault, 1975/1977) represented only one way of conceiving of the "procedures of power":

> Bentham thought and said that his optical system was the great innovation needed for the easy and effective exercise of power. It has in fact been widely employed since the end of the eighteenth century. But the procedures of power that are at work in modern societies are much more numerous, diverse and rich. It would be wrong to say that the principle of visibility governs all technologies of power used since the nineteenth century (Foucault 1977/1980, p. 148).

The "procedures of power" operating in the encounters from which both Bloor and McIntosh's and May's respondents accounted for are 'lost' to some considerable extent because of the distance imposed by using only interview accounts. In May's case, while members may account for their care as resulting from their ability to 'fix' problems requiring solution, missing from such accounts of practice are the researcher's observational cross-checks which serve to extend an analysis into the accomplishment of 'fixing' as a nursing action.

The paradox inherent to this argument is recognized. While on one hand criticizing these researchers for not 'visualizing' the practice they report on through means of observation in addition to the verbal accounts, I am at the same time criticizing May and Bloor and McIntosh in particular for taking Foucault too literally on the notion of the 'optics' of power. A distinction must be made with regard to the use of the visual metaphor. The distinction is of import to the planned collection of research materials for the present study.

The danger in limiting the research materials in the way which May's study in particular has done to just interview accounts of action is that the interpreter of these materials must take into account that the respondents' version of action is 'mediated' in particular ways. I would argue that this mediation will be heavily influenced by organizational features of the work setting, and not merely psychologistic differences, such as Field's category of "perspective" (1983, p. 9). Washing differential accounting procedures out to psychologistic mechanisms flattens the theoretic potential of the data.

While a researcher's observation of action will also be 'mediated' in particular ways, the conscious effort to remain open to alternative readings does distinguish this form of research materials from the accounts given by staff or client members. I would argue that the critical stance taken when considering a *combination* of research materials (ie. researcher-generated observational accounts, interview accounts from staff and client members, documentation of encounters) facilitates a significantly more robust reading of the action of practice than single source studies can provide.

This is not a minor point but rather underlines a primary concern addressed in the present thesis. Two apparently opposing perspectives on the nature of 'experience', 'knowledge', and 'action' are called into question. To suggest, as May does, that in the objective reality of nursing work the effect of the nurse's therapeutic gaze is that of 'fixity', a version of power which is merely constraining is implied. I would accept that knowledge, as it is understood in the day-to-day context of practice, offers members engaged in interaction facilities which can be drawn on in order to 'fix' meanings. In this sense, background 'theoretical' knowledge deployed by nurses can be viewed, in Giddens' terms as "structures" (1984). However, the 'fixity' accounted for by nurses in May's study may be an effect of power exercised during the action which is accounted for at a later time. What is still missing from these accounts of practice is how the appearance of such 'fixity' is accomplished. Picking up Foucault's warning that "it would be wrong to say that the principle of visibility governs all technologies of power", the question becomes, what are the other "procedures of power at work"; procedures which can be considered alongside the visual but distinct from it, procedures which can be advanced as contributing in "diverse and rich" ways to govern the "technologies of power" at play in the practice relationship?

What the studies reviewed in this section have in common is a focus on *accounts* of practice. With a view to the possibility that the answer to the above question might well be addressed were the *practice of nursing itself* the focus of analysis, in this way again re-orienting notions regarding 'the field' of practice, the discussion now turns to investigate studies which have attended more directly to the nurse-patient interaction.

3.2 Analyzing conversations in nursing practice

Attending to subtle shifts of conversation studies conducted by Mortis (1990) and Hunt and Montgomery-Robinson (1987) demonstrate a promising turn towards 'the field' in order to generate understanding about how practice is accomplished. These researchers have used conversation analysis as a method for analyzing the way in which 'nursing practice' is constituted in language.

Based on the seminal works of Harvey Sacks, Emmanual Schegloff and Gail Jefferson, conversation analysis has been influential in its own right as well as demonstrating applicability within the ethnomethodological tradition (Schegloff & Sacks, 1973; Sacks, Schegloff & Jefferson, 1974; Schegloff, 1968, 1987a, 1987b, 1988, 1992, Watson, 1992). Heritage has described the work undertaken by Sacks and his colleagues as "courageous and perceptive" (1984, p. 235). Heritage points to the dominant force at the time represented by the work of linguists such as Chomsky who held that social interaction was a random process and therefore entirely problematic in terms of its possibilities for analyses.

Certain of their belief that human interaction *was* coherent and meaningful in practice, Sacks, Jefferson and Schegloff's work continued in the face of such criticism. Their view was that the apparent coherence and meaningfulness of social interaction could only be explained through the discovery of some form of organization, however hidden it appeared to their contemporaries. As a result of their persistence, Heritage remarks that the analyses of conversations conducted since their early work has produced a "strongly cumulative and interlocking" body of knowledge of use in examining the organization of social interaction (1984, p. 234).

Arising from this theoretical base, Hunt & Montgomery-Robinson (1987) document a study which begins similarly to Boyle's (1991) as these authors ask about the 'problems' faced by nurses working in the community. The difference is that Montgomery-Robinson maintained her focus on how the 'problem' was constituted and managed *within* the practice setting. She addressed what she took to be a particular 'problem' for community nurses, that is, gaining access to patient's in their own homes in the community. In fact, as Hunt and Montgomery-Robinson note, gaining access is not in 'reality' a problem for

nurses at all. It is accomplished routinely by health visitors as a part of their daily work. The study demonstrates how such an act is accomplished so apparently unproblematically.

Of particular note in their report of the methods used is the distinction made between the results of previous studies which have concentrated on categorizing communication in nursing practice as a series of behaviours. The advantage which is claimed for conversation analysis is that it "present(s) movement" (Hunt & Montgomery-Robinson, 1987, p. 152). Unfortunately, the authors do not speculate on the nature of this movement. I would argue that the 'movement' again points to the ineffaceable presence of 'the social'. These authors are unable to extend their argument as they lack an adequate conception of action linked to their understanding of conversation.

A study using the techniques of conversation analysis was undertaken by Mortis (1990). The materials for this study were obtained from an antenatal ward of a large Canadian teaching hospital. As a nurse teacher, Mortis was concerned that the rule-based method of teaching students "communication skills" did not accurately represent the form which communication takes in everyday nursing work. Perceiving that a more "reality-based" (Mortis, 1990, p. 48) theory was unavailable in the nursing literature, she adopted the approach of conversation analysis to investigate some of the underlying characteristics of nursing talk in practice situations. As such, this represents a study which treats the field seriously as a site where nursing practice is constructed.

Mortis' central finding, based on only two recorded interactions between nurses and patients, was that "'I' talk" by the patient, was not "supported" by the nurse (Mortis, 1990, p. 202). Mortis claims that the effect of this is that the patient's experience of a problem is disrupted. Eventually, perhaps after several unsuccessful attempts to have the problem acknowledged by the nurse Mortis claims that "the meaning of events in their experienced context is lost" (p. 202).

Through the mechanism of not supporting "I" talk, Mortis detects a discrepancy in power between the participants in the recorded conversations. Mortis describes a number of conversational techniques employed by nurses to transform patients' experiences of hospitalization. Concerned with reflecting her

observations of practice against an 'ideal' model for nursing communication, one which advocates attention to the patient's definition of problems, Mortis claims that patient experiences are "reduced to a state of 'no trouble'" (p. 203). The transformation of the experience of patienthood, accomplished as the exercise of power through conversational strategies can only be treated by Mortis as a "reduction". Although Mortis' analysis has identified instantiations of powerful discourse, she offers no further exploration of the structures which constrain and enable the production of such scenarios.

The significant contribution of a study such as that conducted by Mortis is that it signals an attention to the notion of power in the discourse employed by the nurse to accomplish her work. The power is not physical nor obvious, it leaves no visible scars. Instead, the analysis demonstrates the immense subtlety of power in discourse, the pervasiveness so clearly evident in Foucault's writings; the 'punishment' of non-response to a voiced complaint, the 'discipline' involved for patients to become complicit with the nurse in the eventual framing of 'problems' as 'no trouble'.

3.3 Identifying criteria for 'good' practice

Mortis' study can be contrasted with one claiming a similar starting point, that is, the nascent state of debate regarding nurse-patient relationships. Morse (1991a) approaches the 'problem' of nurse-patient relationships using what she describes as the "techniques of grounded theory" (p. 456). Her approach represents the failure to consider a crucial point made by Schegloff (1988):

> Instead of beginning analysis with the seemingly special features of the persons, settings, or occasions actually being examined, investigators might do well to begin with more general ways of organizing talk, one not limited to specialized jobs or settings, and ask how the more general resources are adapted for particular, situated use (p. 455).

Not unlike Lawler's (1991) claim that nursing lacks theoretical space for the 'body', Morse claims that "there is no theory about the process of the developing [nurse-patient] relationship" (1991a, p. 455) available to nurses. Refusing the notion that nurses and patients draw on "general resources" (Schegloff, 1988, p. 455) of everyday talk, adapting these for health care encounters, Morse

demonstrates a common presentiment about theory in nursing as something which is lacking and which therefore should be produced for the consumption of practitioners. This position can be described as one of 'filling-the-gap' between what is taken as 'best practice', informed by existing theoretical formulations, and empirical findings which never quite measure up to these ideals. Representing the functionalist perspective, Morse demonstrates the way in which such a view of theory production is instantiated as essential for the improvement of practice. As such, Morse's position exemplifies the discursive practices used by Melia ten years ago which were challenged in the introduction to this chapter.

Addressing what she characterizes as a 'lack', Morse produces a typology of relationships consisting of the "clinical", the "therapeutic", the "connected" and the "over-involved" (1991a, p. 458-459). From this typology Morse generates statements such as "clinical relationships often occur when the patient is being treated for a minor concern" (p. 458) yet, with data consisting only of interviews with nurses, such a statement seems cavalier at best. Morse suggests that the resulting relationship depends on a number of factors, many of them "outside the control of the individual nurse" (p. 464), for instance, specialization, the multiplicity of care givers, and the "lack of time to spend with the patient" (p. 465). Rather than illuminating the process of how relationships are negotiated, such studies only provide devices to further legitimate present organizational features within which such relationships are reproduced.

Morse's concern is to reduce accounts of processes into similar conceptual boxes. This work is facilitated by the 'speed' implicit with the grounded theory approach whereby analysis is required to occur simultaneously with data collection. This, I would argue, represents a mis-guided emphasis on 'getting close' to practice as it is conducted in 'the field'. Validity of findings can not be enhanced merely through the speedy production of 'themes'.

The alternative position suggested by Schegloff's remark that participants in health care encounters draw on existing theoretical notions (possibly adapting them for particular use, that is, 'institutionalizing' them) advertises the advantage of setting aside studies which aim at mere 'gap-filling'. Schegloff cautions investigators regarding "the contingencies of professional practice"

(1988, p. 455) in attempting to apply the principles of conversation analysis to practices other than those of everyday conversation. Such a warning is taken up in Hunt and Montgomery-Robinson's (1987) work where they suggest that the analyst may find it beneficial to contrast institutionalized talk with mundane talk in order to discover the "specialness" (p. 153) of professional conversations.

On the face of it, Schegloff's (1988) warning is appealing. Certainly the position of this thesis is one which would concur with his claim that investigators would do well to "ask how the more general resources (of talk) are adapted for particular, situated use" (p. 455). However, when this warning is taken up in the way formulated by Hunt and Montgomery-Robinson (1987) a difficulty arises immediately. That difficulty has to do with the privileging of 'everyday' talk over 'professional' talk. How is such a distinction to be made? A conception of power as not only constraining but also enabling action and the constitution of subjects for practice must be considered.

3.4 Analyzing conversations for 'difference'

In the United Kingdom, Silverman's work (1987) has drawn heavily on the methods of conversation analysis. Silverman's research has been concerned primarily with the description of medical consultations arising in paediatric out-patient clinics. He has investigated relationships developing between doctors and parents of children with Down's syndrome (1981), cleft-palate (1983), cardiac involvement and cancer (1987) and more recently with adults in AIDS counselling (Silverman and Peräkylä, 1990).

Silverman addresses the issue of interpenetration between discourse, knowledge and power directly. He acknowledges that the impossibility of separating these concepts except analytically has led to a "tarnishing" (1987, p. 263) of the view that mere 'enlightenment' to a current state of affairs will necessarily remedy the situation. It will be recalled that Morse's (1991a) study was aimed at just such a remedy. Morse claimed that a "wise nurse" would be committed to the multiplicity of goals operating in an organized health care event and would balance the priorities of competing goals "for the good of the patient, for the good of the profession and for the good of herself" (p. 467). Failing to consider the

implications of taking professional talk as generated through 'general resources', Morse's study demonstrates a privileging of the professional over the everyday.

As demonstrated above with Silverman's work, conversation analysis has been used in the analysis of medical discourse to underline the difficulties of privileging professional talk in this way. West (1990) draws on the techniques of conversation analysis to examine differences between what she terms "directives" (p. 85) given to patients by male and female physicians. Attending to the effects of power within interactions, her analysis concludes that male physicians tend more often to draw on directives which take the "form of an imperative" (p. 108), positioning the physician in an hierarchically superior position to the patient as someone with an inalienable right to direct. Conversely female physicians were observed more often to phrase their directives to patients in a "mitigated" (p. 108) form which "minimized status differences between physician and patient and stressed their connectedness to one another" (p. 108).

Significantly, West notes that it is not so much the similarities exhibited by physicians from one gender or another that are of interest but rather, those instances where female physicians were observed to make their directives more imperative, just as male physicians were observed to make their imperatives more mitigated. She suggests that here lies the ground, within the "mundane activities of social life" where the resources for "doing gender" (p. 109) are located. Such a perspective avoids the dualism of male versus female ways of 'doing physician' by instead entering the debate addressed by Gherhardi (1992) in her Goffman-esque examination of the social constitution of gender in social organizations.

Importantly, such approaches retain 'difference' as an inherent analytic device. This crucial turn has been explored in some detail by Rabinow (1986) and Strathern (1987a) as crucial to a critical analytic project. This position will be examined in the final section of this chapter.

A criticism of conversation analysis advanced by Bjelic and Lynch (1992) is apposite. While acknowledging the important part played by conversation analysis within the wider ethnomethodological project, they note that attending to 'the ordinary' and 'mundane' in conversations bears a cost in analytic terms:

> conversation analysts may find it more sensible to investigate how doctors interview patients or inform them of diagnostic outcomes than to investigate how they organize *diagnosis*. What gets lost in the bargain are the uniquely identifying features of the work studied ... The medical gaze becomes subservient to the interests of initiating and sustaining a line of talk, while the patient's body primarily becomes a site for the selective activation of the turn-taking system of conversation (Bjelic & Lynch, 1992, p. 76).

For a study concerned not merely with what is done in the name of health promotion as an aspect of nursing practice but rather how these practices are mobilized in terms of 'encounters' between members within situated health care contexts which is of concern in this thesis, an account of the language of practice from a strictly conversation analysis perspective is, on this view, inadequate.

Instead, a way forward which attends to the influence of power and 'the social' on action must be able to mark shifts and movement within the practice relationship as it is constituted within the field. While conversation analysis offers a way of demonstrating the process of the relationship, that is how utterances follow on from one another, it cannot necessarily explain the 'following' as signifying the presence of relays of power. A wider perspective which takes social action as instantiated through language offers such a possibility to the analytic project.

4.0 Experience and movement: validating interpretations of social constructions

Once 'the subject' of nursing has been de-centred as a certain, objectifiable and rationally based set of practices, an appeal to objectifiable external sources upon which to validate findings becomes impossible. For who now will be the 'expert panel'? Where can we turn to establish the validity of findings generated within the social constructionist perspective?

Cohen (1992) locates this 'problem' within the very process of interpretation in what he describes as our "inclination to generalize" (p. 349). The process of interpretation necessarily depends on the ethnographer's project of making sense of what is seen and heard; of translating one form of text into another. Cohen cautions against making a "theoretical virtue" (p. 349) out of the practice necessity.

Drawing attention to what is, at times, a deeply suppressed reflexivity fundamental to interpretive research, Cohen's warning is particularly suited to analytic projects which attend to 'difference'. But, how can difference be conceptualized in nursing practice? There are a number of social theorists whose work illuminates just this problem. The discussion turns to consider now, more directly, how the relationship between the researcher and 'the field' will be treated in this study.

The concepts of 'experience', as it was developed in the previous chapter, and 'movement' are central to this discussion. Experience is understood within the present thesis to represent expressions of difference. This position is reflected in Gadamer's statement that,

> experience is initially always experience of negation: something is not what we supposed it to be. In view of the experience that we have of another object, both things change--our knowledge and the object (Gadamer 1960/1989, p. 354).

The mark of an event as an experience to be recounted by a member of the group under investigation or by the researcher rests in not only the recognition of something new, but in the object having been recognized in a different way than expected. Gadamer's crucial point about experience arising from *within* its own historicity is underlined. For the experience of negation is only possible when the previously held understanding of the object is available for reflection against what is experienced as different from expectations. To reiterate, experience is taken within the context of the present thesis not as an incremental process of accumulating experiences, based on a rationalist version of better knowledge as suggested by Benner (1984). Rather, the perspective adopted here is one in which experience can be treated as a totality of continually expanding "horizons" (Gadamer, 1960/1989, p. 302) fully implicated in the on-going accomplishment of understanding in the day-to-day events of the life-world.

This version of 'experience' sits alongside the concept of 'movement' as the sensual (Cohen, 1992), or 'bodily' response to 'experience'. Such an understanding of movement used within the analytic project of this thesis has been developed by Lyotard (1979/1984) and recently advanced by Munro (1993b).

Lyotard has developed the idea of 'moves' and 'countermoves' in language games from the writings of the later Wittgenstein (1958). Munro (1993b) situates Lyotard's writings within a wider consideration of social action drawing on notions of power and the embodiment of control technologies. The aim in field studies, I would argue, is to consider 'movement' *in context* so that it bears application for the terms of validity required for a robust theoretical position towards studies of practice. This will now be explored.

The position I am advancing is that 'movement', achieved by linguistic and discursive strategies, can form a field for the researcher to relate to. Within this field, interpretations can be tested, questioned and reflected upon. Ultimately the interpretations can be revised if, at some later point, due to the nature of 'experience', the researcher comes to understand these events in a different way.

The nature of the 'movement' accomplished then, locates the researcher's gaze. For example, if the stated aim of the workers at a particular community health clinic is to promote the health of individuals attending the clinic, the researcher's focus will be on the manner in which this 'action', as a form of 'movement', is achieved. From which position does the nurse begin? How does she 'move' during the encounter? What is the patient's response to the nurse's 'moves'? How does the patient become positioned? How does this position constrain the patient? What is the patient able to accomplish from her position? How is movement expressed by nurses and patients? How does it affect their future conduct?

Questions such as these were put to the materials gathered in the field and are expressed in written form in the chapters which follow. The aim of these interpretations is to re-orient discussions about practice by addressing the field, not as an unchanging physical setting, aspects of which can be controlled through an appeal to external sources of validity, but rather, as a life-world of which and from which members have and generate experience. The field is everything members make use of to enact practices together; it is made present (thought not always visible) through their linguistic expressions and is accounted for in both

verbal and behavioural terms as they move themselves and others around in the field.

This movement, to reiterate, will be explored in the context of this thesis as an effect of the differences marked by social actors based on their experiences of the field, formulated through power relationships and through the accomplishment of hierarchical domination in social encounters. An example of an analysis which takes this shift seriously is Okely's (1991) paper which examines resistance. In this paper Okely re-examines "the context of resistance" (p. 3) as not necessarily fully explained within a perspective which plays subordination off subservience. Instead, by exploring two cases of 'defiant moments', she speculates on the possibilities of individuals being capable of resistance while remaining in positions of subordination. Remaining alert to differences within discursive structures, Okely demonstrates the potential for broadening an otherwise simplistic view of domination and resistance such as that demonstrated by Bloor and McIntosh (1990).

5.0 A note on writing 'the field' provisionally

Having raised the issue of provisionality earlier in the chapter the discussion turns to consider some practical aspects of the approach taken within the analysis and writing up of the research materials. The primary concern that arose during the preparation of data for analysis involves the treatment of action after its occurrence. At the point of transcribing audio-tapes, action might be understood as being frozen into the form of 'data'. As an important aim of this study lay in the examination of nursing practice as action situated in time and space the perspective of 'frozen data' presented a danger within the overall project envisaged; that of losing the vibrancy of the action observed.

A practical strategy employed during the collection of research materials, to be addressed more fully in the next chapter, was that of ensuring the materials were collected from sources which could be triangulated during the analytic phase. In this way, the danger of freezing action is avoided by attending to multiple accounts of action. Such accounts offer the analyst insight into the mobility of meanings and understandings accomplished through action.

A second way of maintaining the vitality of the action recorded during the collection of research materials was to treat the collection itself as an active event. 'Action' involved a variety of accomplishments such as the negotiation of access at the political as well as the participant level, the conduct of interviews with participants, and the production of transcripts. These represent different 'approaches', in an active sense, to the setting in which practice was taking place. That is, 'practice' as a site for research, was approached from a variety of angles with the aim being eventually to leave the site with as composite and integrated a description of practice as possible.

The view of practice sought was not of a linear type, but rather that of an understanding of forms of action. Research which takes the linear approach is apparent in the nursing literature, frequently labelled as grounded theory research (Stern, 1980; Stern & Harris, 1985; Stern & Pyles, 1985; Dodge & Oakley, 1989; Luker & Chalmers, 1990; Cowley, 1991). The researcher is characterized as entering the setting and, following a brief, initial period of generalized observation, moving on to study "core variables" (Morse, 1991a, p. 456). These variables become the focus of future interviews with participants and observations of action taking place in the research setting. Such an approach to research, can be described as linear since it suggests a forward progression during the collection of data based on analysis occurring simultaneously with data collection. A sense of efficiency is conveyed in that two jobs are taken care of at one time.

The danger with such an approach is the fore-closure on the full potential of interpretation. Crapanzano (1986) illustrates the dilemma facing the ethnographer at the point of analyzing the data accumulated during fieldwork:

> The ethnographer conventionally acknowledges the provisional nature of his interpretations. Yet he assumes a final interpretation -- a definitive reading ... The ethnographer does not recognize the provisional nature of his presentations. They are definitive. He does not accept as a paradox that his "provisional interpretations" support his "definitive presentations" (p. 51-52).

While "acknowledging" that interpretations made of ethnographic material are "provisional" the ethnographer is characterized by Crapanzano as being caught

up in a paradox whereby "definitive presentations" are based on "provisional interpretations". In a demonstration of active forgetfulness, the ethnographer claims to get to the 'root' of a mysterious cultural ritual, forgetting that such a root only appears because she has previously positioned the tree in the location it currently takes above the root. Crapanzano treats this phenomena almost as a trick of the nature of interpretation, something which writers need necessarily to guard themselves against.

Cohen (1992) is more specific regarding the nature of writing provisionally. For him the problem arises through the historical development of ethnographic writing in which the ethnographer has taken a position of dominance with regard to the field. To the extent that this domination filters through to the research materials collected in the field, there is a danger of "privileging the analyst's hearing over the indigenous voice" (Cohen, 1992, p. 349). The dilemma is, of course, that it is only by hearing the indigenous voice that an interpretation can be attempted. Cohen's recommendation is to attend in a rigourous way to the theoretical categories drawn on in 'making sense' of these voices.

Leaving the formal analysis until all research materials have been collected does not guarantee that fore-closure will not occur. However, it does offer the opportunity to reflect, to return to these materials over time. Decisions made during collection regarding "core variables" (Morse, 1991a), efficiently followed up in a linear fashion, leave the analyst with an unnecessarily shortened version of action informing the life-world of the participants. It concretizes the 'provisionality' of interpretations by removing the fullness of the description. By prematurely focussing on aspects in the situation felt at a particular point in time to be 'significant', alternative readings are effectively severed at that point.

Every attempt was made in the course of collecting materials from the field for this project to remain as open as possible to the changing life-world on display before the researcher. Openness is necessarily limited by the ever-present movement inherent in understanding as described by Gadamer. Strathern (1987a) has demonstrated how this 'fact' can be turned to advantage:

> Every inversion we deploy is self-referential ... but the deployment of *particular*, concrete inversions is not. The particularity creates a context, defined necessarily by the internal referencing itself as "outside"... Any such contextualisation can of course be recaptured as in turn self-referential, in the same way as "other" can always be collapsed as a version of "self". But to regard this last position as a final one is to *hide the movement* through which it was reached (Strathern, 1987a, p. 279, emphasis in original)

Strathern takes a self-conscious approach to fieldwork, an approach which remains aware of the inversions deployed in an effort to preserve difference. I would argue that from within this self-conscious and critical approach to the field the "positions" referred to by Strathern are maintained in analytic 'play'. Keeping positions provisional, analysis then excavates the "movement" through which positions are attained. Strathern's comment reflects the complex, systematic approach to the field advocated in this chapter. By re-orienting the approach taken to 'the field', preserving difference and the domination it implies, a critical analysis can offer valid representations and explanations of organized action which attend to difference and power as consequences of the social enactment of practice.

Approaches to the life-world of practice should be made with a questioning mind, one which constantly problematizes understandings. The result to be aimed for are rich, contextualized materials reflecting social interaction which offer the potential for explaining conditions supporting routinized actions across members and locales. Provisional explanations can be offered regarding the conditions under which such changes to routine action might take place. The advantage of having extensive research materials available for future consideration is that explanations can be collapsed and re-built in different ways to reflect new 'understandings' of movement arising through experience.

Any interpretation necessitates the building up of stories emerging from the field. Some stories will do more work at offering explanations of action than others. The ability to return, to work up 'new' stories, based on new understandings interpenetrated by structurated experiences, remains the primary advantage to the rich potential of field studies.

6.0 Summary

Concerned with the apparently naive treatment of power and knowledgeable action within many contemporary studies of nursing practice, this chapter has addressed some central issues to be given consideration prior to entering the field in order to study how social action influences the practice of nursing.

The nature of 'field studies' as they are presently represented in nursing research was problematized. It was suggested that use of the term 'field studies' and 'ethnography' has been abused in many nursing studies. Reasons for this abuse were linked to unexamined perceptions that researchers operate under pressure from 'practice' to construct prescriptions for 'good' practice. It was argued that this has had the effect of turning researchers' gaze away from 'the field' of practice, in search of information about populations who at varying times come into contact with nurses. As a result, understandings about practice situated within 'the field' of practice are infrequent. It was argued that, as practice can only be constituted within 'the field', a study concerned with understanding how practice is constituted must necessarily have a much clearer notion than that currently available in the nursing literature of what constitutes 'the field' of practice.

Re-orienting the notion of 'the field' involved examining issues of validity for, once the social constructionist perspective is taken, previously held notions of validity as an appeal to external sources located in an objective reality cease to apply. The 'authority' of member's accounts, triangulated with a self-conscious approach to observing action in the field maintains language as a structure through which power is exercised in the foreground of an analysis of action. Studies which examine the language of practice were reviewed and the importance of establishing such studies on adequately conceptualized theories of action and accounts was underlined.

The importance of maintaining a value on difference was advanced as a central tenet to re-orienting discussion about validity in interpretive research. Taking as a background for this discussion Lyotard's work on language games and applying this to notions of experience and movement, it was argued that

questions raised about the validity of interpretation must now be addressed 'within' the field. That is, having de-centred the subject of 'nursing' as an objective reality, the bases upon which judgements are to be made regarding the constitution of practice also come under review. Placing a value on understanding difference not only has implications for the validity of the interpretive project but also on directions for analysis.

The issue of provisionality was also addressed as it re-establishes a value on reflexivity in interpretation. Cohen's warning regarding the unacknowledged privileging of the analyst's hearing over the voices constituting 'the field' was raised not only as a reminder prior to entering into an examination of the materials drawn from 'the field' for this study, but also as an apposite reminder of Strathern's position regarding the advantage of preserving difference as a distinctive value of field research.

Having established a perspective on the present state of research into nursing practice as well as a theoretical position with which to approach the materials gathered in 'the field' of practice, the thesis now turns to more practical matters. In the following chapter the setting where the fieldwork was conducted will be described. Issues surrounding the collection of research materials will be explored in anticipation of 'entering the field'.

CHAPTER FIVE

Research Materials for Studying

the Language of Practice

> When they cried "we cannot " and "we will not ," Mottyl shivered. The wolves had never made such a sound--in her experience. Never before had they seemed so mortally afraid. She wondered what it could possibly mean.
>
> Doctor Noyes, who was busy folding up and deploying yet another personal and confidential missive deep in the pocket of his sleeve, made a guess that, for all anyone could know, might have been correct. He said to Japeth, still on his knees by the shimmering trough; "I can only suggest that your wolves are suddenly and unaccountably afraid of water."
>
> "Wouldn't they tell me if they were afraid?" said Japeth.
>
> "*Haven't* they told you?" said Noah. And with that, he turned away and returned to his arbour.
>
> T. Findley, Not Wanted on the Journey (p. 34)

1.0 Introduction

The collection of materials for a study concerned with the 'how' of nursing practice involves making decisions about what will count as legitimate sources of information. In Timothy Findley's version of the biblical tale of Noah's preparation for the immanent flood, Japeth demonstrates just the sort of restricted view of research materials crucial to avoid in the development of a contextualized account of practice. Finding Noah's suggestion that the wolves are afraid of the water incredible, Japeth retorts that surely the wolves would tell him if they were afraid. The wolves voices have changed and Japeth can no longer recognize the meaning. Noah's interpretation of the wolves is said to

arise from "a guess that, for all anyone could know, might have been correct" (Findley, 1984, p. 34).

The problem to be addressed in this chapter, based on the critical review of the research literature in chapters three and four, rests in the problem formulated by Findley: how is the analyst, faced with voices and behaviours arising in multiple, possibly unrecognizable forms, to make an interpretation which is based more securely than that given by Noah in Findley's tale. While it is acknowledged that the responsibility of interpreting texts arising from the field lies with the analyst, the aim is to provide a reading of these texts which does not rely on an appeal to a higher authority for credibility. In this chapter the materials collected and the conditions surrounding their collection will be described in order that an approach to analysis can be outlined which capitalizes on the variation of materials arising from the field.

In the following sections an introduction to the setting from which materials for this study were collected will be presented. Keeping in mind the limitations for analysis arising from the critique of Field's and Benner's work, the aim is to describe how materials were collected so that the multiple voices contributing to the constitution of the field of practice were recorded.

1.1 Implications of structuration theory on the conduct of fieldwork

Members engaged in encounters are taken, within the context of this thesis, to be knowledgeable agents, drawing on interpenetrated structures of signification, legitimation and domination to constitute nursing practice. Power is taken to be inherent in language but language is not viewed narrowly as the verbal utterances exchanged between nurses and patients. The language of understandings by means of which actors make sense of action taking place around them is also understood as an important aspect to be recorded during fieldwork. Power is not always displayed through presence but also, and importantly, through absence. Thus what is *not* said can be as important as what is said. This calls for a detailed recording of action observed in the research setting. Unannounced changes to an unspoken agenda can, in this way, be examined during analysis.

This points to considerations of time and space in the planning of fieldwork. What occurs before an observer's eyes is understood as historically situated; observations occur at a moment in time and are situated in very particular spaces. It is with that moment, in its' particular time and space, that something of the 'how' of practice is expected to be revealed. This is not a flat, isolated snapshot. Rather, what is implied is a description of activity steeped in the history of its own occurrence which includes the social actors constituting it.

1.2 Problematizing time and space in ethnography

In order to capture the historical and spatial character of episodes of nursing practice, the ethnographer takes slices of the life-world of those actors participating in the production and reproduction of practice. Guyer (1987) describes the problem for anthropologists who attempt to reconstruct longitudinal descriptions and explanations of village life drawing from accounts written by anthropologists of decades past. This problem has implications for the present thesis. Linking slices of member's life-worlds obtained during fieldwork for later description and explanation, are only problems of degree, not type. Guyer suggests that relying on functional categories of task description or time allocation risks a result in which "social organization drops out, and with it all the arenas of struggle and modes of cooperation" (p. 248) making up the observed practices.

The contrast set up by Guyer involves, on one hand, a description based on categories imposed by the analyst on actions observed in the field, and, on the other hand, that of a detailed descriptive narrative of the activities entered into by social actors. 'Activities' already holds notions of some imposed rationality which must be guarded against. A full description is one where actions observed include a mother entering a clinic with a baby in her arms and a toddler by the hand which 'count' equally as an activity as do the ways in which nurses call mothers into clinic rooms for an interview. Action directed by nurses can not be privileged over those which only appear to take place 'naturally'. The questioning attitude towards the historical and spatial implications of all action must be maintained throughout.

1.3 Writing culture: preliminary considerations

This is the attitude of ethnography--the writing of culture (Clifford & Marcus, 1986). In preparing to enter into the culture one is going to 'write', consideration is given to how to make the entrance, how far 'in' to go, what to look for, what to look at, when to leave, and how to leave. It has been argued that ethnography has shifted from being concerned with details as 'facts' to a concern with the activity of writing itself (Geertz, 1988, Fardon, 1990). Such a shift reflects a greater questioning of the material world as a 'factual' one. Of interest in reading ethnographies is not whether or not one agrees with the place where the writer stopped questioning as much as asking why she stopped there. The difficulty of writing culture is one of monitoring the borders which are constantly being written. The aim is to be as aware of those borders as possible, to erect them as provisionally as possible, so as to permit examination and reflection upon what has been written but also to enable the re-tracing of steps as to how that effect was achieved.

The account which follows reflects the steps taken by myself as a researcher entering the field. Written post hoc, it contains considerations arising in the present on reflection of the past. It is an account of the 'equipment' which was used to enter the field, some of which was found to be too heavy, some absolutely essential for survival.

The account consists of preliminary descriptions of the locations from which materials were collected. Additionally, descriptions of the nursing staff and the clientele they work with is provided. These descriptions are aimed at familiarizing the reader with some of the names and terms in use by the social actors in these settings, terms which are used frequently and which will be developed analytically in the chapters which follow. The process undertaken to gain access to the setting will be described and the practical accomplishment of fieldwork will be presented. Names of nurses, clients and locations have been changed to protect confidentiality.

2.0 General description of the setting

Hillcrest Clinic is a community health clinic located in a Canadian city. The clinic is operated under the auspices of a municipal administrative department providing community health services to a city of approximately 700,000 people. Fieldwork was conducted at Hillcrest Clinic from early May until mid-July, 1990.

The clinic is located beside a shopping centre and shares a parking area with the neighbourhood public library. It is located close to a major public transport stop. The clinic space is shared by the nursing division and the dental services division. All services offered are administered by the municipality however funding for community health services is a provincial matter. Administrative offices are located in the downtown area of the city, a thirty minute drive from Hillcrest Clinic.

2.1 Services offered at the clinic

The nursing division operates their services under the following "mission statement":

> In collaboration with individuals / families / communities, the Nursing Division is committed to working towards optimal health for all (persons living in the city) by focusing on reducing health inequities through the professional delivery of effective nursing service.

The mission statement, while directed at the local population, includes specific reference to current political orientations for health services. For example, part of the World Health Organization's (WHO, 1986) goals for Health for All by the year 2000 aims at reducing health inequities (Kickbusch, 1981; Milio, 1986, 1990). The reduction of health inequities will occur, it is claimed, through the delivery of "professional" nursing services. A copy of the mission statement is taped to the outside of the Nursing Manager's office door. It is visible only to staff members. Visitors to the clinic are rarely taken to that corridor. The mission statement was never referred to during interviews with staff members.

Services provided from the clinic include childhood health and developmental assessment, childhood and adult immunization services, pre- and post-natal classes. Staff working from the clinic also provide services beyond

the physical structure of the clinic in a variety of locations within the boundaries served by the clinic. Services offered by staff in the community include:

a) hospital liaison visits to collect names of mothers who will be discharged from hospital following the birth of a baby,

b) home visits to mothers recently returned home following the birth of a baby,

c) visits to day-care centres to give talks to children on health topics (brushing teeth, immunization, nutrition),

d) routine visits to elementary, junior and senior high schools to give talks on health topics ("family life" education, nutrition), to be available on a 'drop-in' basis for students and to give routine immunization to fifteen year olds, and

e) routinely staffing seniors 'drop-in' centres in a variety of locations in the community where elderly residents can come for advice on health matters.

2.2 Physical layout of the clinic

There is a car park directly in front of the building. There are two signs in the car park. The first one reads "Clinic Staff Parking Only". The second sign reads "Private Property - any unauthorized vehicles will be towed away at the owner's expense". There is no specific indication where members of the public using the clinic should park.

Inside the front doors is a sitting area seldom put to use by workers at the clinic. Standing in this waiting room, a visitor is confronted by two counters. To the right is a counter behind which the nursing division receptionists sit. To the left is another counter, for reception of clients for dental services. It was uncommon to find any one sitting behind this second counter.

From the front entrance, most individuals are directed by the receptionists into the clinic room by turning to the right and entering through a swinging door. Staff and 'selected' visitors can, instead, walk towards the hall way directly ahead. At the end of the hall way, a door opening to the right leads to the staff coffee room. Following the hall way around to the right leads to staff offices.

Inside the first office, each nurse is allocated desk space. It is a small room and is used by nurses to complete paperwork or to make telephone calls. Further down the hall way is a room which the staff describe as the "library". This room can be brought into use with some effort as an extra clinic room. The refrigerator

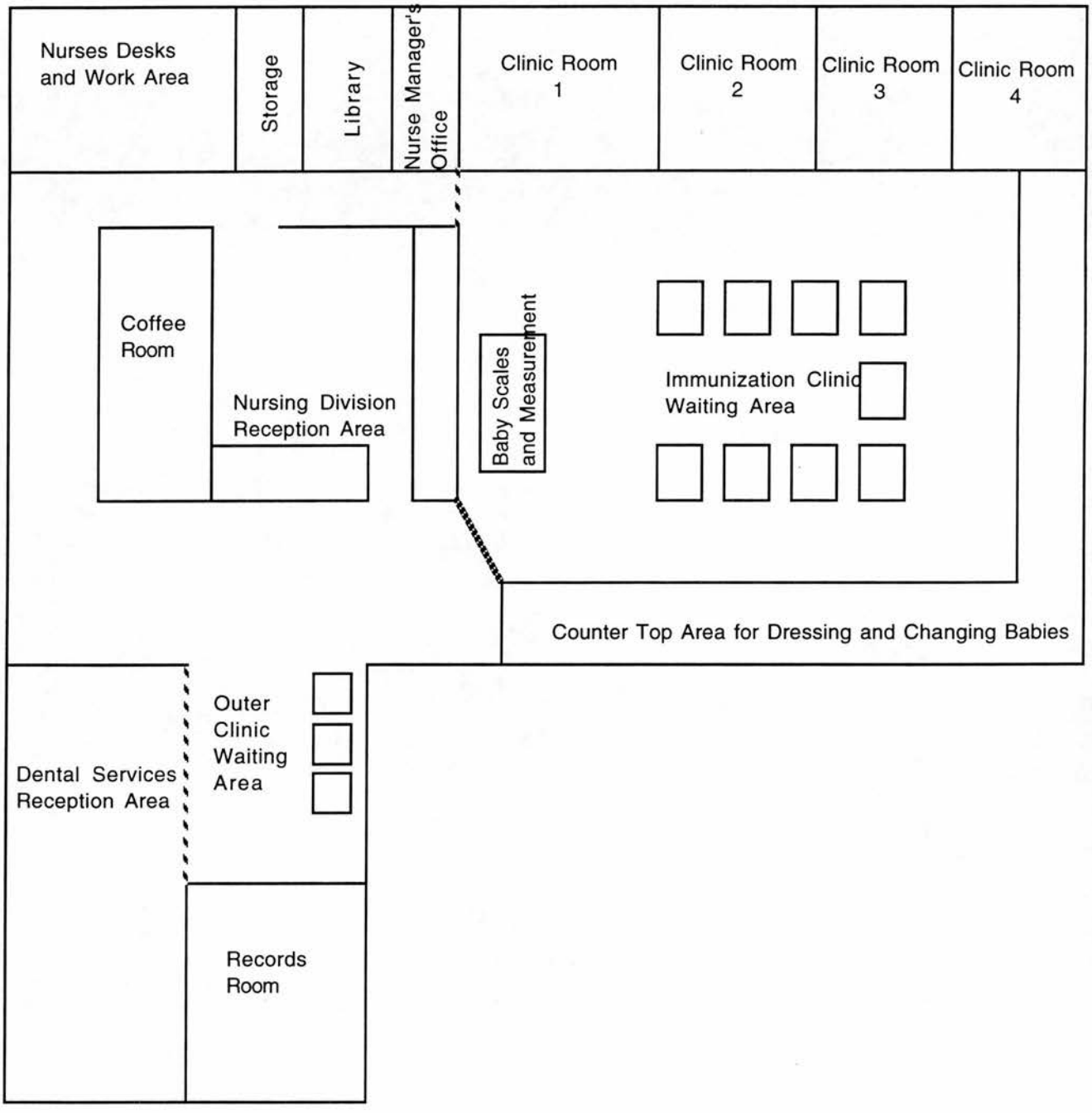

Figure 1. Floor Plan of Hillcrest Clinic

where all vaccines are stored is located in this room necessitating staff access at all times. The room thus lacks privacy. The last office is used by the Nurse Manager. Although she was observed to be frequently away from the clinic attending meetings at the downtown office, this room was never used for anything other than administrative purposes.

At the end of the hall way is the back entrance to the clinic waiting area. A toy box is located at the far end of the waiting room. All around the outer wall is a counter which staff encourage parents to use when changing children's diapers or removing children's clothing in preparation for immunization. The counter has a two inch, raised edge on the outer aspect, a safety feature for parents using the counter. The floor plan of the clinic is shown in Figure 1.

The clinic contains four separate interview rooms. Each room has a desk and swivel chair located in one corner of the room and an office chair situated beside each desk. The walls in each room are decorated with large, brightly coloured posters of Disneyland characters and other cartoon figures advertising the benefits of brushing teeth or being immunized. On the wall in front of the desk is a large diagram of a medicine dropper showing specific measurements such as "0.5 mls." and "1.3 mls.". The nurse sits in the swivel chair behind the desk, parents sit in the chair beside the desk. Most offices also have small wooden chairs where pre-school children are encouraged to sit. Each office has a window overlooking the park area behind the clinic. A diagram of a clinic room is shown in Figure 2.

The nurses keep the desks supplied with materials used for developmental testing and immunization. For example, eye testing kits, syringes and extra cotton swabs are kept in the desk drawers. On top of the desk a tray containing a small yellow thermal pack contains vaccines kept at a cool temperature. A dish with cotton swabs is kept beside a container filled with fluid used to cleanse the skin prior to immunization. Additionally, file folders with printed material given to parents during the clinic visit are located on top of the desk.

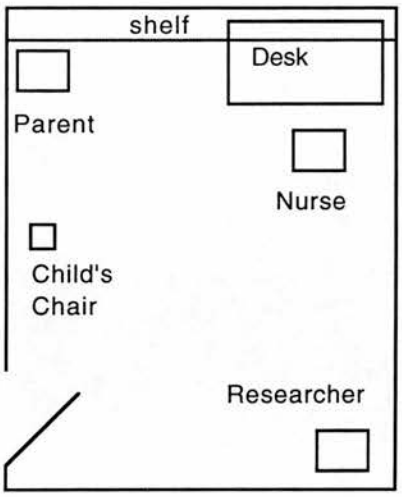

Figure 2. Clinic Office - Hillcrest Clinic

3.0 Members working from or making use of clinic services

Observation conducted at the clinic suggested that it was the central hub for the work of the community health nurses. All staff members were required to attend weekly "staff meetings" on Monday mornings. Each staff member was scheduled to work two or three "immunization clinics" held Monday to Thursday. Morning clinics ran from 9:00 a.m. to 11:30 a.m. Afternoon clinics ran rom 1:00 p.m. to 3:30 p.m. Full-time staff rotated through evening clinics held one evening per week. Each nurse took a turn at being "office nurse". This involved a nurse being available to respond to 'relevant' telephone calls made to the clinic. This "clinic work" was observed to be regulated by means of rotating schedules and obligatory attendance. The nurses' presence for clinic work could be monitored by the clinic manager. In contrast, nurses scheduled all their own appointments in the community, making this work relatively 'invisible' from the manager's perspective.

The term 'members' is used to designate all individuals who make use of the physical setting of the clinic as an identifying location for the work accomplished. In practice, the work, on occasion, took place at some distance from the clinic.

3.1 Staff members

Fifteen nurses are employed at Hillcrest Clinic. All but one of the nurses have a baccalaureate degree in nursing. The nurse who does not have a nursing degree holds the qualification of Registered Nursing Aide and is called a Community Health Nursing Assistant (CHNA). Early in the fieldwork this nurse's job was observed to consist of greeting parents at morning and afternoon clinics, weighing and measuring children brought to the clinic for immunization and recording this information on the child's clinic record. This nurse was later re-allocated to clerical work such as filing school immunization records. The other nurses' then were required to take over the duties previously undertaken by the CHNA, a change not generally approved of by the staff.

Ten nurses work at the clinic full-time. Five nurses work on a part-time basis. The nurses range in age from their mid-twenties to nearing retirement age, however, the majority of staff were in the range of 35 to 40 years of age.

Five nurses agreed to participate in the study. Three of these nurses were in the 35 to 40 year age bracket, one was 58 and the other was 27. All but the 27 year old nurse were married and had children. All the nurses except for the 27 year old had worked at the clinic for more than five years, either in a full- or part-time capacity.

The other two members of staff were the receptionists who had no formal nursing background but who had both worked at the clinic for over 10 years. It was the receptionist's job to make clinic appointments at the completion of each visit for the next scheduled immunization. Children received immunizations at the clinic at two, four, six, twelve, eighteen months and then again at five years of age. Although the visits were clearly organized around this prescribed regime for immunizations, the work the nurses did was referred to by the receptionists as "counselling". If phone calls came in to the clinic for a nurse who was involved in a morning or afternoon clinic session the receptionist would inform the caller that the nurse could not be called away at present because she was "counselling".

3.2 'Client' members

Given the nature of the study, that is, informed by a social constructionist framework, the term 'client' will be used to refer to members who are the object of nursing work. As this work involves the subjectification of these clients (May, 1992b) to varying degrees, the terms client, parent, and child will all be used to designate members as these roles are constituted within the context of nurse-client encounters. When referring to research conducted on the practice relationship in a general sense the term patient will be retained where appropriate.

Thirteen clients participated in the study. Eleven of the clients were encountered in the immunization clinic. Of the other two participants, one was observed in interaction with a nurse at a post-natal home visit and one was observed at a Senior's Clinic held at a Senior Citizen's residence located in the community. The client from the Senior's Clinic was 76 years old, female and lived residentially where the Senior's clinic was held. She lived alone in a small, private room.

The other twelve clients were all females between the ages of 24 and 43 and were seen by nurses at the clinic for the purpose of having their children immunized in all but the case of the post-natal home visit. The children were aged between three weeks to five years of age. Five of the clients were having their first and only child immunized. The other six clients all had between one and three other children who had previously been through the process of clinic visits for immunization.

One of the clients managed a small business out of her own home. One worked part-time as an ultrasound technologist at a local hospital and one client was about to return to full-time clerical work following six months of maternity leave. None of the other clients were employed outside of the home.

All the clients who brought their children to the clinic for immunization were married and all but one had a husband who was in full-time employment. The client whose husband was unemployed was the only one living in rented accommodation, all the others lived in homes they owned or were in the process of buying. The area of the city in which the clinic is located is primarily

residential and many of the houses are between 30 and 50 years old. Many of the clients have purchased older houses and are in the process of renovating them. Others have built new, smaller houses, referred to as "in-fills" following the demolition of the pre-existing older homes.

4.0 Negotiating access to the setting

Negotiating access to a research setting was found to be a much more time and energy consuming process than is generally recognized in research handbooks. For instance, Polit and Hungler (1987), widely cited in nursing literature as a reference text for nursing research, do not include the step of negotiating access in their overview of the research process. Field and Morse (1985) make reference to the fact that organizations may make decisions on the "feasibility" (p. 51) of a research project, but gloss the problem by claiming that "once the formal clearance is completed entry to the study group can proceed" (p. 51).

There are two levels at which access is negotiated in a research study. First is at the political level. The project is put under the magnifying glass of the organization's hierarchy to determine 'flaws', 'faults', or any other 'reasons' why such a project cannot be carried out. At this level I was informed of the importance of ensuring that "proper" forms were completed, using "appropriate" terminology. Such requirements are treated in detail by Mortis (1990) who reports her experience of gaining entry to a hospital to make video and audio recordings of nurse-patient interactions. She claims that it was conversation analysis, the methodology chosen for her study which made this process "extremely difficult" (p. 78). In line with Mortis' experience, it was found that attempts made to obtain materials from hospital settings for the present study were met with scepticism and concern on the part of hospital administrators. Individuals in positions to permit access for research purposes, approached the collection of 'naturally occurring' conversations between nurses and patients as "dangerous" (Douglas, 1975) territory. All manners of exclusion can be brought against would-be researchers.

Such 'exclusions' are also experienced at the second level of negotiation, access at the 'participant' level. This was found to be an on-going process, never one which was fully and finally achieved. It became apparent that 'participants' in the research project could re-negotiate their participation, as noted by Schegloff (1992), on a "turn-by-turn" (p. 1338) basis.

At the political level, discourse about the format and use of "consent forms" can be viewed as the outcome of attempting to apply some form of 'technological control' onto the level of 'participant' access. Interestingly, Polit and Hungler (1987) devote two pages to the topic of "informed consent" (p. 22-23), include two glossary entries on consent and an appendix entry demonstrating a model for the development of a consent form. Such demonstrated concern for 'forms' displaces a more relevant discussion regarding the process and achievement of access to a group of socially organized practices. In the following sections this displacement will be addressed.

4.1 Political access

Negotiations for research access to Hillcrest Clinic began in mid-February, 1990. Preliminary negotiations were conducted between myself and the Assistant Director of the Nursing Division whose identified area of responsibility was nursing education. As a senior manager, the Assistant Director's office was located at the downtown office. An informal discussion regarding the goals of the fieldwork took place. I was advised by the Assistant Director that specific forms would have to be completed in order to formally apply for access to undertake research in one of the community clinics. Assistance in this process was offered and accepted.

The first draft of the application was reviewed by the Assistant Director of the Nursing Division and the Director of the Research and Development Division. The major concern voiced by these individuals was the plan for obtaining clients to participate in the study. The original plan was that parents attending immunization clinics with their children would be approached by the researcher, informed about the research study and asked to participate in the study.

It was suggested by the managers that, because parents attending the clinic would not be expecting to participate in a research project, direct contact between parents and the researcher was problematic. To alleviate direct contact the Director of the Research and Development Division suggested that the clinic receptionists could telephone parents booked for an immunization clinic, inform them of my presence in the clinic and my interest in having the parent participate in the study. If the parent was interested, he or she would be given my telephone number to seek further information. As the suggestion did not significantly alter the original research proposal, this was incorporated into the second draft of the research application form.

The concern addressed by this alteration to the initial plan was that perceived by administrators to be an apparent power differential between myself as the researcher and parents. The effect of the change, that is, having the receptionist phone the parent to seek their willingness to participate, was designed to act as buffer between the parent and the researcher; an attempt to 'equalize' the relationship.

At issue, but unacknowledged by any of the administrative members, was the manager's assumption that negotiation was not required on behalf of the clinic staff and their interventions in the immunization process. There was no consideration give to the notion that the telephone call made by the receptionist could be read by the parent as a 'demand' to bring the child in, or as a form of surveillance on their intention to fulfil their obligation as a parent to have their child immunized. Childhood immunization is not mandatory in Canada although it was observed during the fieldwork to be treated as such by staff members at the clinic.

As noted above, appointments for immunization were made at the completion of the previous visit. Calling the parent to inform them about the study and to seek their willingness to participate precluded a decision by the parent not to attend the clinic. Additionally, in practice, the receptionists were observed to work diligently at getting parents to call to enquire about participating in the study. After phoning four or five parents, the receptionists would call me to ascertain their 'success' rate. Very often they admitted being

surprised that "Mrs. X didn't call. She sounded very interested on the phone." It was made clear to me that the receptionists were adapting the message provided to them as part of the research proposal. The message provided is displayed in Figure 3. The receptionist's adaptations were framed as encouragement for parents to participate.

> Mary Ellen Purkis is a nurse studying the process of communication between nurses and clients. She would like to be present when you come to the clinic for your visit on _(date)_. Mary Ellen would like to audio-tape record the conversation which takes place between yourself and your nurse and then ask you a few questions afterwards. Because your participation in this study is voluntary, I would ask that you give Mary Ellen a telephone call if you would like to take part in this study. Her telephone number is _(number)_. You can ask her any questions you have about the study at that time.

Figure 3. Telephone message read to potential clients by Clinic Receptionist

Following preliminary acceptance of the proposal by the administrators I was asked to attend a meeting of the Research and Development Committee. The Committee meeting, chaired by the Director of the Research and Development Division, was held on April 10. A copy of the research application had been given to the committee members prior to the meeting to enable them to ask questions about the research project. Following the meeting they were to make a decision regarding access to a community health clinic.

Only two questions were asked. One involved a clarification of terms used in the literature review section of the research proposal (I had used the phrase hospital "ward" and one committee member thought that hospital "unit" was a more appropriate phrase). The second question concerned the availability of a measurement tool which would assist in the collection of research materials from the setting. I explained that the use of measurement tools were inappropriate to the designed study. Instead, I was concerned with capturing 'naturally occurring' conversations from the setting and obtaining descriptive

data surrounding the occurrence of the conversations. This response was accepted by the committee member. No further questions were asked.

I was informed by telephone later that day that permission had been given by the Research and Development Committee to go ahead with the research project. This informal message was followed up by an official letter from the Medical Officer of Health. The Assistant Director for the Nursing Division informed me that plans with the nurse manager of Hillcrest Clinic could proceed.

4.2 'Participant' access: staff

During meetings with senior managers at the downtown office, Hillcrest Clinic had been identified as having a reputation for being "well managed". Both the Assistant Director of Nursing and the Director of Nursing agreed that Hillcrest Clinic provided a wide variety of services in the community. Other clinics were contrasted with Hillcrest as being primarily concerned with services for mothers and babies due to the demographic make-up of the community. Hillcrest Clinic was said to offer opportunities to observe nurses at work with not only mothers and babies but also senior citizens and school children. Methods for obtaining access to staff, school or senior's groups was not raised as problematic by these managers. The access 'problem' seemed only to arise with regard to parents having their children immunized at the clinic.

Following a meeting with the Nurse Manager of Hillcrest Clinic on April 25, it was arranged that I would attend a staff meeting on May 7 to present the research proposal to the staff and to seek their written consent to participate in the study. Nine staff members were present for the meeting. I was introduced by name and academic affiliation by the Acting Nurse Manager. The Nurse Manager was out of the clinic on April 25th for meetings at the downtown office. I presented a brief outline of the research project and in more detail, the expectations which I would have of those nurses willing to participate in the study. A period for questions was allowed during which clarification was sought regarding participation in the study.

Questions arising were concerned primarily with clarification on the use of the tape-recording equipment and a concern regarding their ability to produce

enough encounters of the sort I was seeking. For instance one nurse was concerned that I would not be able to observe a home visit because she had very few new mothers in her district.

An interesting feature of this introductory session were the nurse's declarations regarding 'interest' areas. One nurse suggested that I book one or two sessions with her as she conducted a "Senior's Drop In Clinic" every second Thursday at a local senior citizen's residence. It became apparent only later that all the nurses were responsible for running Senior's Clinics in their own districts. None of the other staff members, however, suggested that I attend these. It also became apparent later that the nurse who suggested I attend the Drop In Clinic also worked at two of the regularly scheduled immunization clinics each week. She did not specifically suggest that I observe her at work in this location and indeed, demonstrated some surprise that I would wish to observe and record these contacts. Thus, while five nurses provided written consent at the completion of the verbal presentation on April 25, I had to negotiate access to each contact which nurses had with clients on a case-by-case basis.

4.3 'Participant' access: clients

Thirteen clients were observed and audio-tape recorded in interactions with nurses from Hillcrest Clinic. Eleven of these contacts were conducted at the clinic itself during immunization clinics. One was conducted in the client's own home and the final contact was at the Senior's Drop In Clinic. Eleven contacts were made via the clinic receptionists intervention of phoning prospective clients at home a day or two before the clinic visit had been scheduled. Three or four clients were observed at three different immunization clinics.

Of those clients who called me following the telephone call from the receptionists, only one chose not to participate. The reason given for not participating was because of the follow-up interview scheduled two weeks after the clinic visit.

The client observed during the home visit was selected through a similar process as those selected for the immunization clinic. The nurse setting up the meeting with the client read a message adapted from the one used by the

receptionists. As the client did not have a telephone she was not able to call me to talk prior to the interaction being observed. However, it was agreed by the client that I could arrive at her home twenty minutes prior to the nurse's expected visit. During that twenty minute period, the study was explained and the client's written consent was given for the observation and recording of the interaction.

At the Senior's Drop-in clinic the selection of clients was altered slightly. Because of the nature of a drop-in clinic, the nurse would not know ahead of time whom to expect. I accompanied the nurse to the clinic and was present in the clinic room when the clients entered. The first client to arrive for the clinic was asked if she would participate in the study. Following a brief description of the study she agreed and was asked to sign a written consent form. The interaction with the nurse followed immediately. This was unfortunate as it is recognized that elderly clients are frequently characterized in the research literature as being in a relatively powerless position to refuse participation in research. All clients were treated with respect in regard to their agreement to participate.

For all clients, other than the client observed at the Senior's Drop-In Clinic, there was a brief period prior to the formal interaction with the nurse for me to talk with them. Each client was asked if there were any further questions prior to my observation of their encounter with the nurse. Few of the clients had any questions during this time. The clients observed at the immunization clinic appeared pre-occupied with watching their children and being alert for a call from the nurse that their "turn" had arrived. Both the clients observed away from Hillcrest Clinic appeared pre-occupied also; the new mother in ensuring a tidy appearance for her house and the elderly client in ensuring she was first into the clinic room to see the nurse.

All clients gave the appearance of being more relaxed and less concerned with time during the follow-up interview two weeks after the recorded interaction with the nurse. I was, however, constantly aware that 'access' to information from the client was very much provisional. A sensitivity to the

'mood' of the client was at the forefront of each interview, testing the extent to which access would be permitted.

For instance, the client interviewed following the Senior's Drop-In clinic initially agreed to provide me with information about herself. When asked about her relationship with family members however, access was bluntly denied. At such junctures I was left to make on-the-spot decisions about trying to obtain further information. "Deep probing" (Field, 1983) would have been inappropriate in the situation with the elderly client.

Alternately, other clients were 'heard' to make side references to events or persons of apparently little importance in the scheme of talk at the moment. However, by attending to such side references, these often turned out to be of significance to the client and their understandings of health. For instance, one client spoke extensively of her mother's influence in her life but very little of her father's other than to 'mention' that he and her mother had been divorced seventeen years earlier. Upon probing this matter further the client informed me that her father was chronically ill and that her mother divorced him so that she could devote her attention to her children. The event of her parent's divorce had remained an unresolved issue for this young mother and was a matter of consideration in her present dealings with health care professionals. Over the course of an hour and a half, access to information was maintained by careful attention to references made by interviewees.

No guarantee can be offered that all such references were picked up during the fieldwork. Ribbens (1989) and Robinson and Thorne (1988) suggest that it is at this point in the research process that the researcher's power is most noticeable. Ribbens states that researchers should demonstrate a

> sensitivity to the ways in which particular social characteristics will affect our research relations. How this affects the balance of power in the interview may be very significant for the talk that ensues (1989, p. 581).

Certainly there was a constant awareness of *feeling* the boundaries of the interview. 'Pressure' was applied against these boundaries during interviews with research participants in order to access information. While this pressure could be legitimized as an attempt to 'keep the interview to time', or 'keeping the

interviewee on topic' (Field & Morse, 1985) more often alternative accounts could be given for these feelings, for instance, being "positioned" (cf. Lyotard, 1979/1984) as a 'stranger' or as a 'friend'. My position as researcher was affected by the social context within which the interview took place.

In one interview at a client's home I rang the door bell just as the client arrived at the door. The client was attempting to get to the door before the door bell could be rung as her husband was sleeping on the sofa in the living room. The husband arose shortly after I arrived and went outdoors without answering when the client asked him where he was going. When the husband returned twenty minutes later, the client arose abruptly and without explanation from the kitchen table where the interview was being conducted. She switched the electric kettle on and talked briefly with her husband. Only after she had made him a cup of coffee and he had taken it back into the living room did she return to the kitchen table and resume the interview. In this situation, 'access' was temporarily withdrawn in favour of this woman's attention to other family members.

When given mention at all, access negotiation is treated in the literature as a straight-forward event. Once accomplished, all that remains as 'evidence' that access was considered are the letters of formal recognition. This denies the on-going nature and influence of access negotiation. In order to include such information into the over-all interpretations made, field notes were recorded following each interview. Included as a preamble to each transcribed interview such notes provide additional descriptive material in an effort to produce a contextualized account of the interview as a social encounter.

5.0 The collection of research materials

As the issues regarding provisionality of access described above suggest, it was not always possible to follow guide-lines developed prior to beginning data collection. However, it remained important throughout the fieldwork to have a baseline for the forms of materials being sought in order that the decisions to alter the collection of research materials could be made against a back-drop of the initial plan.

Three forms of research materials were obtained: audio-taped recordings of nurse-client **interactions**; audio-taped **interviews** with clients and nurses; and, **observations** made in all settings where clients and nurses were encountered.

5.1 The nurse-client interactions

Thirteen nurse-client interactions were observed. Eleven of these interactions were recorded during routine childhood immunization clinics. Each nurse was observed on at least on two occasions in interaction with clients.

These interactions, though primarily focussed on the administration of a vaccine, were also concerned with assessing the child's 'development'. This second area of focus appeared at first 'hidden' because, though the nurses identify this as part of their "mandate" it is not formally recognized within the context of the interview. When asked about the assessment later, most of the client's did not recognize the conversation prior to the administration of the vaccine as anything more than "social chat" with the nurse.

The nurses appeared to conduct the interview under some amount of pressure to complete the interaction within a twenty minute period. Nurses stated that they were at liberty to extend the visit should they feel this was necessary although this 'option' was not observed during the period of observation.

The nurses informed me that my presence accompanied by the tape-recorder made them nervous and unable to interact "naturally" with clients. The interview rooms at Hillcrest Clinic were generally small and so I was unable to "blend in" with the background as is frequently suggested for "naturalistic" observation (Field & Morse, 1985). Every attempt was made, however, to be as non-intrusive as possible during the interactions. Experienced clinic attenders, that is, clients bringing their child into the clinic for the third or fourth time, were asked whether they noticed any change in the nurse's behaviour from earlier contacts. They claimed not to have noticed any difference. This is not to deny the emotions expressed by the nurses, as behaviours such as nervous laughter, openly acknowledging me as a "shadow" during interactions, and drawing attention to my presence during the interaction did occur. However, as

a method for obtaining both verbal transcripts of interactions combined with observations of those interactions no other less intrusive method could have been employed.

Mortis' (1990) description of her use of video equipment suggests that participants were as aware of the video equipment as they would have been of a person as they were required to switch the camera on prior to each recorded interaction. Additionally, the equipment had to be adjusted by either the nurse or the patient prior to each interaction to ensure accurate recording.

During recorded sessions at Hillcrest Clinic I entered the room with the client, in this way attempting to blend into the setting as all other participants were establishing their places. Located in the corner of the room I was able to control the recording equipment out of view of the participants as well as being afforded an unobstructed view of their actions.

5.2 First Interview

Following the recording of the interaction between the nurse and the client, a short interview with each member was planned. These semi-structured interviews were to last ten to twenty minutes. A number of questions were prepared in advance. These questions were designed to elicit initial reactions regarding aspects arising from the interaction. The order in which the questions were asked altered with each person interviewed, reflecting conversational movements. The questions prepared for the research project are outlined in Appendix A.

5.2.1 Nurses

The purpose of the first interview was to seek 'impressions' from the nurse as to the way the interview had gone, what she had 'picked up' from the client and whether or not she had detected any particular 'problems' during the interaction. Of interest also was an account of how the nurse felt she had 'managed' a particular problem if one was discovered.

Nurses were found to be easily able to respond to questions regarding their own evaluation of the recorded interactions. Generally these nurses were

able to identify specific behaviours displayed by clients which led them to believe that the client had understood what was being said to them. Also the nurses were able to identify how and why they had altered a "typical" communication pattern in response to individual client's responses.

The nurses at Hillcrest Clinic were willing to take time for this interview and displayed no surprise when it was suggested. In one or two instances Interview 1 was not conducted immediately following the interaction due to time constraints for the nurse or myself but each nurse was willing to set up alternate times to talk about the interaction. If the nurse had seen two or three clients in between the recorded interaction and Interview 1, she frequently framed the interview apologetically for she was often "unable to remember" details of an interview taking place perhaps only one hour previously. This suggests something of the 'production line' approach taken to immunization clinic interactions.

5.2.2 Clients

Interview 1 was carried out easily with clients at Hillcrest Clinic. The eleven clients signing a consent at the immunization clinic were informed that I was willing to negotiate this interview depending on how the child who had received the immunization was feeling. In nearly all the cases it was possible to conduct Interview 1 immediately following the interaction with the nurse. Use of a spare clinic interview room was made available by staff members as a location to conduct these interviews.

Clients were found to be able to "recite" the order of what had been discussed during the interaction with the nurse but were less able to specify aspects of the interaction they felt were immediately useful to their situation. The clients reported feeling it would be beneficial if they could see the same nurse at each clinic appointment. They indicated that they felt that the clinic visit would more worthwhile if each visit could be viewed as an investment of time towards establishing rapport with a clinic nurse.

5.3 Second Interview

For the clients, the second interview was scheduled to take place two weeks after the interaction with the nurse. This time period was selected in order that questions regarding changes arising from contact with the nurse could be asked. It was hoped that in this way some determination of the 'significance' of the interaction with the nurse could be made. In addition it represented an opportunity to ascertain certain historical and biographical features of the client's experiences of health, whether formally structured through encounters with health care professionals or in other less formal ways. The aim was to 'locate' the interaction observed at Hillcrest Clinic in a broader context of the client's strategies for managing their health and the health of other family members. These interviews took between one hour to two hours to complete.

For the nurses, the second interview took place towards the end of the fieldwork. The aim was to guard against having interview accounts of work 'intrude' on day-to-day activities observed in the clinic. Information gathered at this interview was designed to obtain biographical information regarding the nurse's work career and understandings of her work at the clinic. Towards the end of the interview with the nurses I informed them of my 'interest' in the topic of health promotion. Specific work activities which the nurses felt pertained to their role as health promoters were discussed.

5.3.1 Nurses

The nurses from Hillcrest Clinic were interviewed on "work time" which was mutually agreeable to themselves and their manager. Two major themes arose consistently in these staff interviews.

Firstly were problems encountered by the nurses during the introduction of a nursing model. Dorothea Orem's (1985) model had been introduced to the nurses and advertised as a method to systematize the documentation of their practice. The second concern arose due to a major re-organization of their areas of responsibility. The re-organization was not to be implemented until September, however, the staff were involved in planning for the re-organization during the fieldwork.

At the time of fieldwork, the clinic was organized along what were described as 'traditional' lines. That is, the staff of the clinic were responsible for provision of all public health care services to the population of a large geographical area. The large area was subdivided into smaller "districts" and each full-time nurse was assigned a district. She was said to be responsible for the population within that area; families, schools, senior citizens, day care centres etc.

In September the clinic staff would begin working in one of three teams: the Maternal-child team, the Senior's team or the School team. Old districts were being dissolved and team members would be responsible, now as a 'specialty' group, for the entire geographic area serviced by the clinic. The staff members differed widely in their views on this change. Some were keen to "specialize", advertised as one of the advantages of the change. Others viewed it as a way for managers to lay-off some of the part-time staff.

In addition to these two identified areas of concern, the nurse manager had informed the staff during the observation period that she would be leaving for a two year educational leave. This influenced the staff's views on the introduction of the nursing model and the work re-organization as the Manager was perceived by all staff as having played an integral role in initiating these changes.

5.3.2 Clients

I met all the clients encountered in at Hillcrest Clinic just five to ten minutes prior to their interaction with the nurse. The consent form provided a useful vehicle for introductions. The presence of a child at the immunization clinic also provided a non-threatening topic of conversation. However, generally it must be said that the process of rapport development between client and myself was focussed and somewhat forced.

Because at Hillcrest Clinic, the focal point of the interaction tended, in eleven of the thirteen cases to be the immunization, this was the usual starting point for the interview. This event was not viewed as a change by the clients who, in all cases was the mother of the child receiving immunization. This

shifted the focus of the interview away from a specific change the client could describe towards what the visits to the clinic meant in general.

5.4 Making observations

Observational fieldnotes were collected from the initial contact with senior managers during the formal negotiation of access through to the completion of the period of fieldwork at Hillcrest Clinic. Research materials arising from time spent at Hillcrest Clinic as well as other locations in the community such as the Senior's Drop-In Clinic and a school immunization clinic were recorded as fieldnotes. Observations made during interactions between nurses and clients were integrated into the transcripts of those interactions in order to portray physical as well as linguistic action taking place during the interactions. Observations made during the interviews were incorporated as a preamble to the transcribed interview.

While the primary source of research materials for this study was the recorded interactions taking place between nurses and clients, the observational notes and interview transcripts played a crucial part as 'cross-checks' on the recorded interaction material. None of the actors positions, including my own, were taken to be 'true'. Following Denzin (1970), use of triangulated accounts were taken to provide a lever to examine the primary source critically. In the nursing literature Duffy (1987b) is frequently cited by researchers referring to the process of triangulation. Caution should be taken with this citation as Duffy's treatment of triangulation resembles that of Benner (1984) whose use of multiple sources as a way of merely providing additional data has previously been criticized.

Duffy's aim is to highlight the benefits of "methodological triangulation" (1987b, p. 131) which she describes as a technique by which quantitative methods and qualitative methods can be used together to extend the findings which either on their own might be able to accomplish. Duffy acknowledges a form of triangulation which she calls "data triangulation" (p. 131) only in passing. It is described as the gathering of

> observations through the use of a variety of sampling strategies to ensure that a theory is tested in more than one

> way, thus increasing the likelihood that negative cases would be uncovered (Duffy, 1987b, p. 131).

Triangulation is treated by Duffy as an extension to singular data sources. For instance, data triangulation rests on the notion that an observer who limits observations to one room of a five room clinic may not 'uncover' disconfirming cases going on in one of the other five rooms. The language of natural science is apparent in this account of triangulation and guides its assumptions. Such an approach to triangulation rests within an assumption about human action where some actions can be said to be more representative of the truth than others. Thus a concern with the generalizability of the various representations arises.

If, as is the case with the present thesis, actions are not taken to be representative of reality, but rather constitutive, then triangulation ceases to be a vehicle for determining truth and instead offers multiple perspectives on the action observed. Rather than being limited to one individual account of what was taking place, as in the case of Benner's exemplars, seeking accounts from as many perspectives as possible on one event provides the analyst with a richness of descriptions not otherwise possible.

Within the context of fieldwork for the study interactions taking place between nurses and clients at Hillcrest Clinic were recorded from three vantage points: the client's, the nurse's and the researcher's. By drawing on all three perspectives a composite reading of the situation arose. This is not to be confused with abandoning the "burden of authorship" (Geertz, 1988). The researcher's interpretation was critically contrasted against those of the other participants. The researcher is not left to accept the nurses' accounts as 'true' as was the case with Field's study of community nursing practice. Additionally, drawing on the potential for triangulation as was incorporated into the present study, I was able to contrast the nurse's account with that of the client's account in order to examine the effect which the nurse's position had on the interaction. So, unlike Benner's (1984) work, accounting for power remains central to the interpretive project.

The importance of observation materials and participant interviews as cross-checks on the primary source of nurse-client interactions cannot be over-stated. The availability of empirical evidence in the form of verbal accounts

made by members in conjunction with the researcher's observations of the location of social action offers a firm grounding from which critical reflection begins and to which one can return in order to suggest crucial links between what is observed and what is accounted for by social actors.

5.5 A note on the preparation of materials for analysis

No formal analysis took place until the completion of the fieldwork. Each recorded interaction between a nurse and a client was, however, transcribed as soon as possible following the interaction. Symbols used during transcription are displayed in Appendix B and an example of one of the nurse-client interactions is provided in Appendix C.

Transcription of audio-tapes proved to be a time-consuming activity. A transcript of the interaction between the client and the nurse was taken to the second interview to be reviewed by members as a cross-check on the accuracy of transcription. Secretarial assistance was sought for the transcription of the interview tapes as these were not required until the completion of the fieldwork period. Transcripts of all nurse-client interactions and interviews conducted with nurses and clients were fully prepared and reviewed by the researcher prior to the beginning of formal data analysis.

Analysis took the form of reading the transcripts systematically, making notes on striking aspects of the transcripts, discussing these findings with supervisors and colleagues and returning to read the transcripts again. In this way, patterns were developed and then 'cross-checked' with other data sources.

For instance, a pattern was noted that nurses tended to review the most recent measurements with parents at the beginning of each interview. Upon 'cross-checking' this pattern, it was noted that this was the case in all but two instances. In two instances, both involving nurse Fran, the youngest and newest staff member, measurements were reviewed with parents once in the middle of the interaction and once at the end of the interaction. Such 'findings' were then incorporated into the developing theorizing of social action in the clinic. All notes of such patterns were kept as part of the developing theory which will be advanced in the following chapters.

6.0 Understanding practice: a launching point for fieldwork

A particular theoretical position has been advanced in the first five chapters of this thesis. Drawing on Giddens' synthetic theory of structuration, the aim has been to extend discussion beyond linear descriptions characterizing much of the literature reviewed in the preceding chapters. An examination of 'how' community nursing practice 'comes off' as though it represented a group of agreed upon practices will be presented. The aim is to offer an understanding of practice relying not merely on actors' accounts but one which uses accounts as a background against which observations of practice can be critically cross-checked.

In the following four chapters research materials will be presented, interpretations made and theoretical statements advanced in order that the central questions raised can be given detailed consideration. The analytic project reported in this thesis is not one concerned with 'proving' or 'predicting' the empirical world of practice. The aim is instead to present an account of practice as it is constituted in interactions between nurses and clients and to explore the conditions supporting practice in its particular constructions. In order to provide some focus on the territory of concern for the analysis, the central questions addressed in this thesis will be reviewed.

The analysis seeks answers to the questions of 'how' actions such as health promotion are accomplished within the life-world of one practice setting. Clients are understood to contribute to the accomplishment of action in ways which may not be 'equal' to but are as significant as those of nurses. The analysis is not limited, however, to a study of verbal exchanges between parents, children and nurses. The materiality of the clinic life-world is included in explorations which aim at explicating action as a *process* engaged in by members attending the clinic setting.

Of particular interest in 'loosening the embrace' between the notions of 'power', 'interests' and 'knowledge' as they are constituted in practice is to respond to a question first put in the introduction to this thesis [p. 13]: that is, how knowledge of what facilitates action is implicated in the viability of interests in practice. Action, understood as a process engaged in by knowledgeable actors

in situated contexts, provides the ground against which such a question will be addressed.

Capitalizing on the availability of transcribed recordings of encounters between nurses and clients in the clinic life-world, a further aim of the analysis is to explore "technologies of power" employed by nurse members in encounters with clients. Picking up Foucault's caution regarding the pervasiveness of the visual metaphor in conceptions of 'understanding', emphasis is placed on remaining open to other forms of power exercised in this practice setting. Thus, analysis seeks to answer another question developed in chapter four [p. 113]: how are practices mobilized in terms of 'encounters' between members in the clinic? I am concerned in the analysis to advance an argument regarding how nurses accomplish the work of understanding who the client is and what work the nurse will do in relation to that client.

The interest in power and it's implications for the social construction of actions *as 'nursing'* arises from the sense that power has received inadequate treatment in much of the research available on practice. Power, as constitutive of nursing action, is evident in Field's (1980, 1983) accounts of nursing practice but remains largely absent other than in her attempts to explain away 'unusual' results. As Foucault (1963/1973, 1975/1977), Giddens (1984, 1990, 1991) and others have identified, the 'late modern age' is one defined by sophisticated and intricate 'procedures of power'. The question arising then is, in the apparent absence of a unified discourse for health promotion, how do nurses conduct practice involving the instruction of clients to make changes aimed at altering levels and forms of health?

The production of 'community health nursing' is treated in the following chapters as a reciprocal process, relying not solely on the actions of nurse members but also on how the nurse's actions are understood and responded to by client members. In the following chapters research materials will be analyzed in order that theoretical statements can be advanced regarding the nature of 'theory' and its relationship to the constitution of practice. The theme of 'orders of knowledge', first introduced in chapter one and developed further in chapter three [p. 57] is underlined here. To reiterate the underlying position of this

thesis: the 'orders of knowledge' drawn on by members to organize practice are understood as being located in the active accomplishment of that practice. This position has implications for a fuller understanding of the concepts of 'theory' and 'practice' than are presently available in the nursing literature. In an effort to 'reveal and describe' order in nursing practice, I turn now to an examination of those members actively involved in constituting practice through interaction; nurses and clients in the life-world of their encounters with one another represent the 'field' for investigation.

CHAPTER SIX

Strategies for accomplishing the practice relationship at Hillcrest Clinic

> There are betrayals in war that are childlike compared with our human betrayals during peace. The new lover enters the habits of the other. Things are smashed, revealed in new light. This is done with nervous or tender sentences, although the heart is an organ of fire.
>
> A love story is not about those who lose their heart but about those who find that sullen inhabitant who, when it is stumbled upon, means the body can fool no one, can fool nothing--not the wisdom of sleep or the habit of social graces. It is a consuming of oneself and the past.
>
> M. Ondaatje, The English Patient, (p. 97)

1.0 Introduction

In the preceding chapters a particular position regarding the nature of social conduct and the means of investigating social conduct within organized practice settings has been put forward. This position, most centrally, concerned itself with proposing a place from which an examination of the practice relationship, as a form of social conduct, could be studied. The aim of the study is to contribute to the nascent but expanding debate on the nature of of nursing work as a social construction (cf. Field, 1980; MacLeod Clark, 1982; Benner, 1984; Käppeli, 1984, 1986; Melia, 1987; Gott & O'Brien, 1990b; Tilley, 1990; May, 1992a, 1992b, 1993; Hiraki, 1992; Holmes, 1992; Latimer, 1993; Mueller, 1993).

The position advanced in the preceding chapters will be drawn on to inform the analysis and interpretation of materials gathered from one practice setting. In the following chapters I propose to examine the constitution of the

practice relationship and the effects of that relationship on conduct in particular contextualized practice situations.

The focus of chapter six is to describe strategies employed by nurses working at Hillcrest Clinic to accomplish the practice relationship. The relationship will be explored not strictly in terms of how it is described (that is, 'intended') by the nurses. In keeping with the position guiding this analysis, the practice relationship is understood as an 'accomplishment'; the result of action not merely on the part of one actor, the nurse, but as work engaged in mutually by social actors.

Lyotard's seminal work (1979/1984) drawing on Wittgenstein's notion of 'language games' will be used here to provide a framework for describing the encounters between nurses and clients in the clinic. The aim is to treat these encounters not as peculiar to the 'discipline of nursing' but rather as indicative of available disciplinary mechanisms drawn on in particular ways by members engaged in interaction in a nursing practice context. Accounts of the relationship from both the nurse's and client's perspectives will be used as background to the action observed during encounters between members. The aim of this chapter is to illustrate the conditions underpinning the practice relationship at Hillcrest Clinic.

In chapter seven strategies for work identified in chapter six will be explored in terms of their implementation as "strategic conduct" (Giddens, 1984) in the clinic. Drawing on the overview of work in the clinic presented in chapter six, the aim is to critically examine how the strategies are put in to use and the effect of these strategies on the practice relationship. Here, Foucault's work (1963/1973) on the disciplinary gaze will underpin an analysis of how bodies are represented in the clinic, how such representations are brought about and the effects of bringing about particular forms of representation on both the nurse and the client. Latour's writings on "enrollment" (1987) will inform a discussion of the concept of 'expertise'. A departure from existing understandings of expertise, primarily those arising from Benner's work (1984), will be advanced.

In chapter eight the discussion turns to examine the modes of surveillance enacted by staff members in the clinic. Analysis of conduct, arising

from theoretical positions illustrated in the previous chapters, will be brought together here in an attempt to demonstrate how conduct in the clinic is "networked" (Latour, 1987) as an effect of the disciplined conduct of staff and client members encountering one another at the clinic. As a condition widely recognized in social theory to influence social relationships located in "late modernity" (Giddens, 1991), surveillance will be examined in chapter eight as a particular mode of practice conditioned by particular aspects of conduct in the clinic. Present representations of the nurse as either passive transmitter of health information (cf. Luker & Caress, 1989; Laffrey, 1992) or as 'powerless' within a health care structure which takes medicine to be an oppressive force to be escaped from will be challenged (cf. Morse, 1991a, Wright & Levac, 1992).

The networking of forms of representation, 'knowledge', and social conduct will be summarized in chapter nine. Here the aim is to discuss implications arising from the particular interpretation made of practice and to suggest future directions for the understandings gained of practice, located within this particular spatial and historical context. A summary of the analysis is offered by way of conclusion in chapter ten.

2.0 Framing the encounter: social 'positioning'

Hillcrest Clinic projects a bright, cheerful atmosphere. This effect is achieved in part by the physical structure of the building. The waiting room is bright, lit by natural light entering through the windows which run the entire perimeter of the waiting room. While it is not possible to see outside from the waiting room, the windows are located quite high, this feature lends privacy to the clinic as it is obscured from view of people who may be using neighbouring facilities. Each clinic office has a window looking out onto the park located behind the clinic. The offices are brightly decorated with Disneyland characters and 'health-oriented' posters.

Cheerfulness is also achieved by the manner in which clients are greeted at the reception desk and by the nurses in the waiting room itself. Documents are passed between workers and service recipients, arrival is noted on the receptionists' appointment list. Friendly but efficient service is suggested.

2.1 Waiting room activity

During immunization clinics the waiting room is a busy, noisy place. Toddlers and pre-schoolers play together in the middle of the waiting room or at the play box off to one side. Three or four nurses work at each clinic so there is a constant 'to and fro' of clients being called into an office or being led out at the completion of the immunization.

Measurements of weight and height of all children attending the clinic are taken. The head circumference of infants up to the age of twelve months is also taken. The act of taking measurements is treated by the staff as a 'pre-requisite' to the more formal 'counselling' session which follows. Progress to the clinic office is treated by staff as being dependent on having this preliminary information recorded on the clinic forms.

Parental assistance is enlisted by the nurse to hold an infant in place on the table to facilitate the taking of height measurements or by holding older children on the stand-up scale should they demonstrate a reluctance to stand still on their own. Once a measurement is obtained it is quickly recorded on a piece of paper, conversions between imperial measures and metric measures are calculated by the nurse. Finally, a recording is made on the documents brought to the clinic by the parent as well as those held on file at the clinic. Only once the measurements have been taken and recorded on the accompanying documents are the parent and child invited by the nurse to follow her into one of the four clinic offices.

2.2 Division of work space

Spaces for work appeared to play some part in ordering the work of the clinic. Encountering a building with rooms clearly marked suggests the possibility of using these rooms for particular purposes. A perception on the part of workers that work may *require* ordering, may be understood as a 'fact' necessitating the division of work into particular spaces. The point is that the physical movement of members from one location in the clinic to another 'announces' the *possibility* that the focus of attention for the encounter may also be moving. A physical move is made from a busy, noisy public space into a

quieter, private space. At Hillcrest clinic, measurements are conducted in public, 'counselling' is conducted in private.

The move to the clinic office facilitates the naming of positions. Chairs are allocated to parents and children. The nurse takes her place at the desk, setting the documents in front of her, then turning on her swivel chair to face the parent and child directly. Now the desk is beside her; she is fully visible to the clients, the clients are fully visible to her. There is no furniture to obstruct the interaction which is about to take place. However, furniture and other clinic accoutrements are available to members to assist them in their efforts to 'locate' themselves and the actions they are about to launch into.

Introductions take place during this period in which everyone is 'finding their seat'. The following excerpt from an encounter suggests the 'friendliness' within which introductions are accomplished by the nurse:

> **Diane enters the office first, followed by Susan who is carrying four month old Jane. Susan's husband, Paul, follows behind. Sitting down, positioning Jane on her lap, Susan looks down at the child and states in a high-pitched voice:**

Susan: We're all going to get shots today aren't we?

Diane: Hi, I'm [Diane], I think I saw you the last time /

Susan: / Yes, yes I remember you.

Diane: I didn't see Dad here, last time.

Paul: No. Dad stayed away ... busy.

Diane: So it's not the threat of an injection for you. **(smiles)**

Paul: **(laughs)** Yeah! No, no, no, no!

Diane: I like to get it clear at the beginning.

Paul: I might cry a little bit ...

Diane: That's OK /

Susan: / Ring that bell for him!

Diane: That's good! See, we're trying to, you know, make the male more emotional and show his emotions more. It's good to cry.

Paul: I'll fall down on the ground!

Paul holds his arm and feigns fainting. All three adults laugh.

Susan: So are you going to give us ours first or ... ?

Diane: I was thinking yeah ... maybe before I inject her ...

Susan: Yeah.

Diane: That's good. How was she with the last injection?

This introduction is characterized by its 'joking' manner. Susan 'announces' the reason for their presence by rehearsing it with the baby. The attendance of both parents at an immunization clinic was observed only on this one occasion and is 'accounted' for by Susan with the announcement that all three family members have come to the clinic for immunization.

Diane does not initially acknowledge Susan's account but rather introduces herself by name and proceeds to establish 'historical' links with Susan. Recognition of one another is acknowledged. Then Paul's presence is drawn on to extend the 'friendly' character of the encounter by making a joke of the immunization as a "threat". All three adult members share in the joke and conclude the introduction with mutual laughter. Susan refers to "the bell", a clinic accoutrement, demonstrating the availability of such material items for members to facilitate 'introductory work'.

While appearing at one level to be light-hearted and inconsequential, this brief introduction has, at another level, accomplished quite a lot of preliminary work. The purpose of the visit has been announced and apparently resolved as agreeable to all members; Paul's presence at the clinic has been accounted for; Diane's position as being 'in charge' of the order in which the immunizations are to be given has been pointed out by Susan; the position of being 'in charge' has been acknowledged by Diane. All this while maintaining the informality of what has now been constituted as a formal encounter.

The potentially daunting effects of moving from the public space of the waiting room into the private space of the clinic office appear to have been 'smoothed' over. This appearance is contradicted only by the possibility of

reading Susan's questions as reflecting some amount of anxiety. Significantly, neither the questions, nor the anxiety they may 'cover' are explored as the counselling session begins.

2.3 The 'business' of the visit

With the introductions complete and members having been directed to their places, the 'business' of the visit begins. As the preceding example suggests this move to the 'business' of the visit emerges rather subtly. In the face of a direct question by Susan regarding the order of the visit, Diane responds by re-directing attention towards the baby.

The label 'client' becomes blurred here. While pre-school children were asked questions directly by the nurse, topics of concern raised with a child contrasted with topics raised with parents. An example is given below. In this case, nurse Kay begins by speaking directly to pre-schooler, Alice, while Alice's mother, Jan, looks on:

Kay: OK. So, I guess it's been a long time since you've been here, right? Do you remember coming here before?

Alice nods her head slightly up and down.

Kay: Do you? What do you remember about it? Anything? Something?

Alice sits looking intently at Kay but does not make a response. Jan leans over to talk to her.

Jan: (2.0) What do you remember? You told me what you remembered on the way in. Heh? What did we come here for?

Alice: (2.5) Vitamins.

Jan: Vitamins /

Kay: / Vitamins. Oh, I bet ... that must have been fluoride you mean, right?

Alice nods her head up and down.

Kay: Yeah. Good. Uhm, we'll just go over a few things and then uhm /

Jan: / Uh hm /

Kay: / uhm [Alice] is due for her little pre-school booster today. Did you know that? [Alice]? Did you know you're going to get a booster today? I'd like to uhm, ask you how you are and I'm going to give you a little eye check unless she's had it before ...

Jan: Actually she just had her eyes checked in school /

Kay: / Did she? /

Jan: / last week.

Engaging Alice in conversation proves somewhat difficult for Kay as Alice's shy responses are reserved to intent looks and slight head movement. Kay's work at engaging Alice in conversation is encouraged by Jan.

The effect, not unlike that of the previous example, is to draw all members of the encounter into facilitating the 'business' of the visit. Jan's involvement in the progress of the visit is acknowledged by Kay as, in her longer turn towards the end of the example, she shifts between Alice and Jan as the object of her speech.

First Kay 'announces' the purpose of the visit ("[Alice] is due for her little pre-school booster today"). The announcement acts as an agenda marker for all members. Kay shifts her attention then by 'checking' this with Alice directly. Kay returns to her agenda regarding the completion of "a little eye check" and then shifts her attention directly towards Jan to ask whether Alice has already had this test done.

While underlining Kay's position as the member in charge of the agenda for the visit, the position of 'client' is less clear. Alice is certainly marked as the object of Kay's agenda but Jan's input is sought and appears to be influential regarding how much of the agenda is considered appropriate. For instance, as a result of Jan's input Kay did 'adjust' the agenda. Rather than testing Alice's eyes for visual acuity at a distance, she conducted a visual test of her depth perception. This test, Jan confirmed, had not previously been carried out.

Alice is treated as the 'client', but a client whose abilities are limited. There is an implication that the tests are designed for Alice's particular circumstances. Jan's responses are sought by Kay due to her 'special' position as

Alice's mother. Kay draws on Jan's identified position as the mother to keep the encounter moving along. Kay addresses specific questions to her, for instance, whether or not Alice has previously had the vision test. Presumably Kay might have asked Alice this question but, as is perhaps typical of the category 'child', the mother's response is treated as being more 'accurate' than the child's.

2.4 Getting on with the visit: completing the form

With an 'agenda' agreed upon in this way, clinic encounters proceed for a period of approximately fifteen minutes during which time topics related to the child's development and general health status are discussed. Nurses use the assessment form (Appendix D) to organize this work. The assessment form is used, however, not only to organize the visit but also is treated by the nurses as an important way of accounting for the work accomplished in the clinic. For instance, nurse Helen suggests that the assessment form is like a mirror, reflecting concerns which parents have regarding their children:

> Helen: I tend to not leave it open right off the bat. Like I'm probably one of the faster nurses that keep relatively on time and yet because I can keep my time frame with covering what we need to know because I mean the bottom line is, I'm after all the information I need, you know, and dealing with mother's concern. You can really get side-tracked before you ultimately get into it?(...) I *really* get a lot of good results that way and it's over and out of the way. And then a lot of times, in doing that the way our format's laid out, you *deal* with a lot of their concerns that, right off the top if you hit it with them when they first come in...

This extract from an interview with Helen following an immunization visit suggests a tight coupling between organizational concerns and parental 'concerns'. Helen acknowledges the place the assessment form has with regard to her demonstration of 'work' within the organization ("I mean the bottom line is, I'm after all the information I need"). However, her suggestion of 'fit' between the assessment form and parental concerns is contradicted by the possibility of getting "side-tracked" by those concerns. If the 'fit' were as good as she claims, getting "side-tracked" should not be as much of a concern as she clearly takes it to be.

Helen's reference to the utility of the assessment form for moving the visit along was shared by other members at the clinic. Helen suggests that her colleagues tend to use an alternative strategy of "leaving it open": in practice the result of that strategy was not dissimilar to the more direct approach advocated by Helen. An example of the "open" strategy in use by nurse Fran is offered:

Fran: How are things going with [Loraine]?

Erica: Good.

Fran: There are no health concerns or ... /

Erica: / Uh-h-hm, no, /

Fran: / anything like that? /

Erica: / no. No she's pretty healthy. She *seems* pretty healthy!

Fran: OK, great! I'll just ask you a few questions here, uhm, she's still on formula now is she?

Erica: Yup.

Fran: OK, any solid foods yet or just /

Erica: / Yup, I've started feeding her pablum.

Fran: OK, is that a rice cereal?

Erica: Yeah, she takes that real good.

Fran: OK, when did you start that?

Erica: Uh-h-h-hm, about two weeks ago, I started her /

Fran: / OK so she would have been three months at the time, right?

This example is drawn from the early stages of a clinic visit. Erica has brought her four month old baby, Loraine, to the clinic for immunization. Fran begins the fifteen minute 'counselling' section of the visit with a general question, one which might be considered by Helen to be 'leaving it open'. Rather than this question resulting in Fran getting "side-tracked" however, Erica provides only brief comments claiming that she is experiencing no difficulties with the baby. This being the case, Fran then draws on the assessment form to move the

encounter along, raising topics such as feeding regimes for discussion. The lack of an identified parental concern is no cause for abandoning the encounter, only one for changing tack.

2.5 Tying up loose ends: moving on to the 'real' reason for the visit

Once all the topics on the assessment form have been discussed, action shifts away from filling in the form towards preparing the child for immunization. The object of the 'assessment' was not observed to be a thorough discussion of topics raised but more that the nurse is able to make a written entry in the space provided on the clinic form.

Parent's, commenting on the fifteen minute 'counselling' session, pointed to the opportunity it provided to recall changes in their child since the last visit to the clinic. Responding to my questions directly after her encounter with the nurse regarding how she views the visits, Erica stated:

> Erica: It seemed fairly, like ... it seemed fairly routine to me. Hmm, it's interesting that they ask what the baby's doing that's different from last time and stuff ... and sort of I don't know, I think to myself, well, then there must be more coming! There's more coming ... so it sort of encourages me.

Questions raised during the encounter about changes she may have noticed in her child led Erica to contemplate all the changes yet to come in her four month old baby. To this extent at least, the encounter has an effect on the mother.

The conversational style of these encounters means that the shift between the 'counselling' section and the immunization section is sometimes quite abrupt. This is in line with Lyotard's (1979/1984) observations that in "conversation", speakers

> use any available ammunition, changing games from one utterance to the next: questions, requests, assertions, and narratives are launched pell-mell into battle. The war is not without rules, but the rules allow and encourage the greatest possible flexibility of utterance (p. 17).

This is to say that the conversational style facilitates such abrupt changes in the direction of the encounter. So, just as previously the 'move' to the private office space was managed by the nurse with light-hearted conversation including jokes

or comments regarding the clothing of the child, the move to the immunization phase of the visit was frequently observed to be 'announced' by physical and conversational movement by the nurse. Discussion of the 'last' topic is signalled as the nurse puts down her pen, sets aside the assessment form and begins to prepare the needle for immunization as the following example demonstrates:

Jill: Sure, well this is where, you know these people will give you *every* angle, you know, the Sexuality will give you every angle /

Bridget: / OK /

Jill: / yeah, OK. OK, so he's going to get this shot which protects him against these three diseases then. I'll just go ahead and mix that up if there's nothing ...

Jill sets the papers aside and reaches into the left hand desk drawer. She turns back to look at Bridget.

Jill: Have you, you've read the measles, mumps /

Bridget: / yeah /

Jill: / fine, haven't you, right.

Jill takes out a red tipped syringe from the drawer. She begins to draw up the vaccine. Bridget talks quietly to the child. He has been playing beside her on the floor for the last few moments. He now gets up on her lap.

Bridget: [Ryan], come here. It's time to get poked.

In this example Jill and Bridget draw the 'counselling' section to a close. Bridget has asked Jill if she has any information regarding the transmission of the herpes virus. Jill refers Bridget on to a 'special' division within the larger organization called "Sexuality Division". The suggestion is made by Jill with no apparent ribaldry; Bridget's question was treated seriously as a 'specialized' problem. The opportunity is taken by Jill to announce the division of labour operating in the organization.

Jill then 'announces' the shift to the final stage of the visit. This announcement comes within an offer to discuss any other concerns ("I'll just go ahead and mix that up if there's nothing ... "). The transitional nature of this part

of the interaction is evident. Jill 'leaves open' the possibility for Bridget to introduce another topic. Here, for just a moment, there is a possibility that 'counselling' could continue. The moment passes and the encounter moves on to the preparation for immunization.

2.6 Sending 'alerts'

The frequency and type of 'alerts' issued by the nurse at this stage of the visit were of particular note. At this point in the encounter, just as in the early stages of an encounter involving a pre-school child, the blurring of 'roles' is quite apparent. While the child remains the object of the nurse's work, that is, the individual receiving immunization, achievement of the immunization involves re-enlisting the parent's physical assistance. As the final stage of the visit approaches, the immunization in this way mirrors the enlistment of parental assistance during the taking of measurements, the first stage of the visit.

In the previous example, Bridget's request for Ryan, her one year old son, to come to her, that "It's time to get poked", stands as an 'alert' both to the child to prepare himself for the immunization as well as for the nurse. Bridget indicates the part she will play in this aspect of the visit. Ryan is lifted onto her knee and held closely by his mother.

Similarly, the nurse sends 'alerts' to parents, warning and instructing them all at once. In the following example, Helen 'alerts' Lynn both to what she expects her to do in order to assist with the process of immunization as well as when she expects Lynn to help:

Helen: Sit on Mommy's lap, actually if you turn her right around. So this arm comes down here and this one back here /

Kathy cries as Helen and Lynn adjust her sitting position so that her right arm is closest to Helen.

Lynn: / Oh! Oh! Oh! /

Helen: / We're going to see how strong Mom is here.

Helen demonstrates to Lynn how to hold the child so that she will not move during the injection. Kathy is crying.

Lynn: (4.0) Oh, goodness. Don't you cry, don't you cry. You're going to be OK.

First injection given. Kathy cries loudly. (20.0)

Lynn: Let me rub. Mommy rub, Mommy rub.

Helen: Oh, Boy! And now let's add insult to injury here.

Lynn turns Kathy around so that her left arm is exposed for second injection.

Helen: (2.5) You got it. That's it. Now if she thought that one was bad hold on for this one.

Lynn: Relax, relax baby.

Second injection given. Kathy cries loudly again.

Lynn: Let me rub, let me rub.

Helen: She's not my friend now.

Kathy crying. Helen sits back in her chair. Lynn holds Kathy on her lap and rocks her back and forth.

The first 'alert' comes when Helen states "We're going to see how strong Mom is here", suggesting that she expects Lynn's hold on the child to be quite firm. The second 'alert' given by Helen comes once Lynn has adjusted Kathy's position on her lap. The 'alert' acts not only to reinforce the importance of holding onto the child tightly but also the timing of the injection. Throughout, 'alerts' serve to position actors in relation to one another. It is the swiftness and requirement for accomplishing those positions that marks the blurring of the 'client' category.

Helen's alerts serve to associate one member with another in quite intricate ways. Addressing the first alert to Kathy, Helen points to an association between herself and the child which relies on the mother's strength. To this point there has been only the suggestion that something painful may be coming; Kathy has already recognized this and has begun to cry. Once the first injection has been given and Kathy has experienced the pain associated with the injection, Helen addresses her second alert to Lynn ("Now if she thought that one was bad hold on for this one"). Now the association is between Helen and Lynn, reflecting the view that Kathy is unlikely to want to participate in this activity

any longer. Kathy's 'position' as no longer 'friendly' towards the nurse is expressed as Helen completes the immunization and the association between mother and child is emphasised. Helen moves away physically from the pair. This movement draws the encounter to a close.

The 'alert' system must be considered beside its apparent effectiveness as a strategy for getting this aspect of the nurse's work accomplished. The examples demonstrate the extent to which the interests of the nurse and the parent are constituted within the interaction as 'coinciding'. Immunization for the nurse represents an aspect of work to be accomplished. For the parent, immunization stands as the formal goal of the clinic visit. The over-lap of warning and instructing constituting the alerts draws on the coincidence of interests between nurse and parent.

This finding contrasts with Bloor and McIntosh's (1990) formulation of the nurse-client relationship as one of resistance in the form of 'concealment'. The implication is that where interests coincide, quite different conditions would appear to be operating in this setting. The construction of 'viable interests' by members engaged in interactions, one of the central questions grounding the analysis in this thesis, is signalled at this juncture. 'Coincidence' of interests, as a consequence of encounters between nurses and clients, will be picked up again presently.

2.7 Terminating the relationship

Having signalled the end of the counselling session by moving on to the immunization, the termination of the visit is emphasised in this dramatic conclusion. Parents who 'check' to make sure the visit has concluded are treated with some surprise by nurses who take this to be 'evident'. Only with an apparently highly 'significant' concern could the nurse be legitimately engaged in conversation again.

This stricture on conduct is demonstrated in the one example observed where a mother did make an attempt to re-enter the counselling mode after the immunization had been given. Her attempt was disallowed when the nurse announced her intention to leave the room.

Following the immunization of her four month old daughter, Kim, Marcia made no move to leave the clinic office. Rather, she sat back in her chair and prepared to breastfeed Kim. During the counselling session, Kim's weight had been constructed as problematic by the nurse. Helen claimed that Kim was gaining weight insufficiently. This 'problem' did not, however, re-enter the 'conversation' at the point of termination. Marcia constructed the matter of concern to her at this particular time as Brian, her two year old boy who was being looked after at home on the occasion of the clinic visit. Marcia indicated that Brian had been waking at night crying and she asked Helen what she thought the cause of this might be:

Marcia: 'Cause we were thinking, like, you know, I guess ... when I was in the hospital with [Kim] that he became very quiet. He wouldn't eat ... and he would just (...) /

Helen: / A little separation anxiety there /

Helen turns away to adjust some papers on the desk.

Marcia: / Yeah, so the *squirrel* was the main thing at that time and he always, always /

Helen: / He's just kept it on, yeah /

Marcia: / used to come to the house. Yeah, and so maybe he's just kept it on ...

Baby cries softly. Marcia looks down and attempts to adjust the baby on her breast.

Marcia: What? Oh-h-h-h, OK. Oh-h-h, it gets better, yeah-h-h-h ...

Helen: **(whispers and looks at researcher)** Isn't she a doll? She's so-o-o-o pale skinned isn't she?

Marcia: Oh yeah, and [Brian]'s dark dark, dark. She is just like white ... but then my husband is pretty fair too.

Helen: (8.0) She says "I just didn't want you to disturb me with your talking." **(whispers)** Oh, yeah but now that we're quiet she's got to see what we're talking about! Now look at that! As long as we were talking loud she was OK. But now something's going on! **(laughs)**

Helen leans over to speak directly to the baby at eye level.

Helen: What's the story there? Hi! Are you going to be sociable again? She knows. She says, "Well, now that you're going to talk to me and I know everything's OK I'll just go back and have a drink." Now, *see* how they *suck* so well.

Helen uses her finger to point at the baby's mouth. Helen looks at researcher then at Marcia.

Helen: That tongue's out and people that try to tell me about kid's biting I say, "There's no way. When the tongue is out around the nipple they *can't bite*." If they're biting you haven't given them enough to grab on to and they're trying to get more you know? Or it's at the end of the feed and they've had enough and they're just jacking around and it's time to put it away and they'll stop that stuff. There's no way the way that tongue comes out ...

Marcia: Well, I don't know whether it's my imagination or, you know, but if I'm talking, see? If I'm talking to [Brian] after work or just it's just kind of pull ... "OK, Mom. I'm eating and you're supposed to be paying attention to me" and...

Helen: Yeah, and see now she's sayin' "Well, what's going on?" I see that little smile gonna happen there. "I'm holdin' Mom's finger."

Helen sits back in her chair and turns to researcher.

Helen: Well, I'm done. Do you want to talk to her while she's still feeding?

MEP: Sure.

Helen: *I'll* leave! **(laughs)** Don't say anything bad now you guys!

MEP: Thanks [Helen].

Helen leaves the room. Marcia continues to breast feed.

Helen treats Marcia's concerns about Brian as though they are not legitimate. She labels the description of his behaviour provided by Marcia as "separation anxiety" and by summarising her impression of Marcia's account with "He's just kept it on, yeah" demonstrates a lack of interest in picking up the topic for further discussion. Instead, using the interruption of Kim's cry, she re-orients attention towards Kim.

Commenting on Kim's appearance, the colour of her skin and then taking on Kim's voice, Helen directs the conversation around to the construction of an apparently irrelevant instruction. Drawing the researcher into her strategy for closure, Helen distinguishes between a baby who is "suck(ing) well" during a feed and one who has "had enough and they're just jacking around".

At the completion of this 'instruction', and before Marcia has an opportunity to turn this into another 'concern', Helen sits back in her chair and announces to the researcher that she is "done". The client-nurse relationship is severed and Marcia is 'passed on' to the researcher. Underlining that termination of the relationship between nurse and client is long past due, Helen stands and leaves the room without further comment to Marcia. It is now myself as researcher who has been positioned to "thank" Helen for 'passing' the client on, not the client for services rendered. Underlining the impossibility of separating the researcher from the field of research, this example demonstrates the 'ease' with which my presence enters into the constitution of practice engaged in by clinic members. Taking Kim's feeding behaviour as an opportunity to give the researcher an instruction, and passing up the opportunity to engage in further work with Marcia regarding Kim's weight 'problem', Helen closes an interaction in which she clearly dominates the agenda.

2.8 What sort of encounters are these?

In the foregoing sections a rendering of 'typical' conduct in the community clinic has been advanced. Examples drawn from different aspects of the encounter have been put together in a collage. That is, portions of different encounters observed during the fieldwork have been presented to provide an illustration of how work in the clinic proceeds. There are two particular aspects of this work which will be examined in greater detail.

These two aspects emerge as a *contrast* which emerged through the analysis of recorded actions. The contrast is between what is so clearly purposive activity on one hand, and the 'friendly' manner in which this activity is conducted on the other. The visits were conducted in such a 'friendly' manner that, when asked later, parents frequently did not recognize the nurse's actions

during the fifteen minute counselling session as work at all. For instance, one mother commented directly after her encounter with the nurse:

> Molly: They're so good with the kids here too like that lady there swinging those bells all the time. I think that's really neat. I feel like they really want to be here. It's not a job, they're here because they want to be here.

This representation of practice in which Molly describes what the nurses do as "not a job" contrasts quite sharply with the nurse's own representations of work. This contrast emerged with one of the nurses during a final interview. The nurse was commenting on an interaction transcript. It is interesting to note the disciplined stance she takes to the transcript. That is, she examines it *as a mirror of her work.*

> Kay: I look at this to see that I tried to follow through on my assessment for immunization and follow up on what they had to do to perhaps could have gone into that in a little bit more detail but ... perhaps sometimes ... it looks as though I was busy doing things while I was trying to talk ... when I look at that now it might be a bit distracting for the parents. I realize I have to give them my full, undivided attention, perhaps it would be better ... **(laughs)** [...] Would it help to set the interview up a little bit more? If we said "You're here for immunization but we also, you may remember from the last clinic appointment **(laughs)** that I'd like to check with you about a few other things, a few other questions ... "

Kay 'evaluates' her performance as a nurse as it has been reflected back to her through the transcript. She draws on theoretical formulations such as the nursing process to undertake this evaluation. She "looks" to "see" whether or not she "followed through" on her "assessment". She criticizes her own performance when she gathers from the transcript that she was "busy doing things" rather than giving the parent her "full, undivided attention". The 'remedy' suggested to repair what she takes to be faulty practice is to 'fix' the encounter *more* firmly *as work.*

The interesting feature is that what the parent takes as 'good' about the encounter is that it is treated by the nurses *not* as a "job" but as something the

nurse "wants" to do. Kay suggests that her performance in the clinic should be remedied by 'fixing' it more obviously, by signalling her actions *as* work actions.

In pointing out this unusual feature of clinic work the aim is not to suggest a concern with whose version holds more 'truth'. Rather what is of interest, and what will be explored in greater detail now is how such versions of work are accomplished in this setting. The 'friendliness' of the setting and what, to the disciplined eye of myself as a nurse and a researcher, looked very much like purposive work, are closely intertwined. The pervasiveness of this form of work suggests, from the theoretical perspective informing this thesis, that it is not merely an unintended consequence of the nurses' actions but may well signal 'strategic' action.

3.0 Context for talk

Encounters such as those undertaken at Hillcrest Clinic are understood within the context of this thesis to be historically situated (Gadamer, 1976; Giddens, 1984, 1991). That is, talk is informed by the spatial-temporal context in which it arises. Encounters between members at the clinic demonstrate the chronic nature of Gadamer's position on historical consciousness. That is, talk in the clinic is not discrete; it does not represent a moment in time unconnected to all previous moments or all subsequent moments. Talk emerges from particular "positions" (Lyotard, 1979/1984). These positions reflect a 'reading' made by social actors of the context within which talk is engaged in. While positions are steeped in an historical consciousness, this is not to suggest that they are immutable. Rather, actors are positioned at specifiable moments within that historical consciousness. I will argue in the following section that nurses explicitly draw on the situated-ness of talk in order to 'go on' in their work.

3.1 A context of 'competing messages'

Visits to the community clinic are, for the parents, only one of many contacts they have with health care services. All the mothers participating in the study had been admitted to hospital for the delivery of their children. Following hospital delivery, mothers were 'scheduled' to return with their child to the

general medical practitioner or obstetrician for regular follow-up visits. Visits to the doctor's office coincides closely with visits to the community clinic for immunization. Unlike their British counterpart, the health visitor, the community nurse's work is not connected in any secure manner to the work of the general practitioner. That is, there are no secure lines of communication between these two groups of health professionals. Rather, they work in near total isolation from one another. The doctor's office does however, constitute one location where parents receive information regarding their child's health.

Parents participating in the study made reference to other sources of information regarding health care. For instance, in the following extract taken from a follow-up interview, Bridget talks about her dealings with a variety of individuals regarding treatment for deep vein thrombosis, a condition she developed following the birth of her baby:

> Bridget: That is what I was going to do when I talk to Dr. [Smith] this time is find out all these things and say (...) if you can't answer it please send me to a specialist. But it seems like even specialists don't have all the answers because I saw one when I was in the hospital and even he sort of said that there is only so much we can do and everybody is different. Gee, thanks! [...] So I don't know. Because of the sort of lack of information that I have had from people and they sort of say there isn't any information that we can give you, it has not made me as anxious to go out and find somebody because I think what is the point. They are just going to tell me the same thing.
>
> MEP: (...) Have you tried, have you found anybody else outside of the doctors and so on that have been able to give you any assistance?
>
> Bridget: Well actually my brother-in-law, [John]'s brother, is in the pharmaceutical field so he has *some* knowledge of things like this and when [husband] was talking to him one night about how frustrated I was, he kind of said well, he said "if she gets out there and exercises, it will clear up". He said "we've seen it clear up in a year".

Bridget describes a sense of frustration with the different messages she has received from individual's in the health care field regarding her 'condition'. She suggests that the advice she has had from these individuals has had an effect on her: that is, she claims that her contacts have "not made [her] as anxious to go

out and find somebody" who will give her an 'answer'. Bridget has constructed these encounters within a frame that no one person has the definitive answer to the problems she experiences with her leg.

There is a tension evident in Bridget's account which is worth mentioning. Clients may not be as passive as Bridget's account suggests. That is, if the client is understood as actively implicated in the construction of 'competing messages', it could be argued that to this point, Bridget has not heard a message which stands out from the rest. The point to be made about the notion of 'competing messages' is that they create conditions of access for a nurse to move in and make her expertise 'count'.

Conditions of 'availability' of health information is reproduced within the context of practice at the clinic. For instance, in her encounter with Paula, a new mother experiencing some problems satisfying her baby's appetite, Helen 'contextualized' her work as a community health nurse in the following way:

Paula: 'Cause, uhm, the doctor wanted me to start him a couple of weeks on cereals.

Helen crosses her left arm over her right, pauses and looks at Paula.

Helen: (1.5) What was his rationale, what did he have to say?

Paula: **(clears throat)** Well, he's a paediatrician, also ... specialist? And uh, he was eating, just eating, eating ... up twenty hours out of twenty-four and /

Helen: / So I've heard some doctors say that it sort of sits solid, sits as a little lead /

Paula: / Yeah! So I said, I said to him /

Helen: / lump in their tummy.

Paula: Yeah, well I said to him, are you *sure* he'll be able to *swallow* and ... ? And is this alright **(laughs)** like are you *sure*? 'Cause to me, that didn't sound right. 'Cause with my *daughter* she was *fine*. And she didn't start eating cereals 'til she was five months.

Helen: That's what we push for. But then, you know, it's sort of ... It's *hard* to sort of say *one* thing when physicians do go ... and if it isn't the physician it's a friend that says "Well I did this and I fed my baby and I fed it earlier than

> they told me and this baby just settled *right down*. And so I'm going to do that with this next baby". We've got a lot of things that you're up against, as far as that ...

In this example Paula alerts Helen to the 'fact' that, at a recent visit to the doctor, Paula relayed the information that her three week old baby seemed to be very hungry. As a result, the physician suggested the baby could be started on solid foods. Paula relays this encounter to the nurse in the form of "the doctor wanted me to" take a particular action.

Paula's constitution of this event draws on the hierarchical structure she perceives herself to be 'caught up' in. The doctor's 'status' is underlined. He is given the title "paediatrician"; he is a "specialist". Against this, Paula reiterates the 'problem' as it had been addressed to this eminent individual: the child, Paula states, "was eating, just eating, eating ... up twenty hours out of twenty-four".

Paula's 'defensive' approach to Helen's question regarding the doctor's "rationale" for introducing solid foods at this stage draws on the notion, already contextualizing this encounter, of competing messages. Paula suggests, as a consumer of these messages, she is required to sift through and make decisions regarding her child's well-being. The doctor's position as a "specialist" points to the difficult conditions surrounding the refusal of such advice.

Hearing the 'difficulties' as they are already being formulated by Paula, Helen reproduces this difficult position in which the mother constructs herself but now turns it to her own advantage. Helen 'moves in' by reiterating that she 'understands' how "hard" it is for parents when they are receiving conflicting messages from other health care professionals. She extends this difficulty to information given by friends.

Helen draws on Paula's own construction of the event and turns it to advantage. She 'agrees' with Paula's stated 'concern' about the doctor's advice. When Paula suggests that her experience with her older child was that she did not begin feeding her cereals until she was five months old, Helen supports this action by underlining the 'official clinic position': "That's what we push for".

Paula's actions have been "enroled" (Latour, 1986) through Helen's act of enlisting Paula's report.

3.2 Accomplishing a platform for work

The outcome of the small segment of social conduct exemplifies the encounter between the nurse and mother as a series of 'moves'. Lyotard's explorations of "language games" offers a way of treating such encounters as social accomplishments. An aspect of consequence in Lyotard's thesis is his simple, yet dynamic, version of the self. The self is characterized as being located at "nodal points" (1979/1984, p. 15). Lyotard's view of the self is not that of disengaged, disconnected individual beings, swirling around randomly bumping into one another now and again (cf. Baudrillard, 1983). Rather, as selves, Lyotard claims that we are already connected to other selves, connected at "nodal points"; this connection is termed "the social bond" (Lyotard, 1979/1984, p. 14). Paula's response to Helen's question regarding the doctor's "rationale" for his instruction to feed a three week old baby, is already connected through an intricate web of social relations. This web effectively positions Paula to hear the doctor's advice in particular ways as well as hearing the nurse's 'challenge' to that advice in particular ways.

The metaphor of the self as located at a "post" (Lyotard, 1979/1984, p. 14) is employed by Lyotard to illustrate how actors connected by the social bond are constantly being moved about by messages. For instance, an effect of Helen's message at the completion of the clinic visit in which Marcia attempts to extend the counselling session is that I find that I am positioned, through my presence as researcher, as the *referent* of the message regarding effective sucking behaviour. Having been earlier positioned in this way by Helen, I then found myself displaced as *sender*, a re-positioning which then had me thanking Helen for 'passing' the client over to me! In accomplishing this re-positioning, I have been enrolled by Helen with the effect that Marcia becomes positioned by us both as the *referent* of the messages.

The effect of positioning is crucial to Lyotard's understanding of language games, that is, that they are governed by a theory of agonistics. Lyotard claims

that moves made as part of the language game have the effect of displacing other players:

> Each language partner, when a "move" pertaining to him is made, undergoes a "displacement," an alteration of some kind that not only affects him in his capacity as addressee and referent, but also as sender (Lyotard, 1979/1984, p. 16).

So it is not merely that an individual language partner might be acknowledged as the sender of a message, but *also* that the message sent comes from a particular position. This positioned message from the sender will, in turn, displace the addressee; that is, the message 'moves' the addressee from their former position (as sender or referent) to a new position (as addressee or referent). It is from this new position that the addressee turns to become sender again, to return another message, aiming to displace the previous sender to a new position. The referent too is displaced in precisely the same manner, like Marcia in the example above, during the play of the language game.

Significantly, such a view of communication accounts for the effects of power in encounters such as those taking place in the community clinic:

> No one, not even the least privileged among us, is ever entirely powerless over the messages that traverse and position him at the post of sender, addressee, or referent. One's mobility in relation to these language game effects ... is tolerable, at least within certain limits (and the limits are vague); it is even solicited by regulatory mechanisms, and in particular by the self-adjustments the system undertakes in order to improve its performance (Lyotard, 1979/1984, p. 15).

Lyotard points to what he regards as motivating the social bond: performance. While displacement is tolerated within limits, movement is not only understood in terms of resistance. Lyotard's crucial move is to suggest that movement "is even solicited". Movement solicited during language games is understood as improving the performance ultimately constituting the social bond.

The claim I would advance, informed by this position regarding language games, is that the accomplishment of a context for talk in the clinic, constructed through references to competing health messages, injects talk in the clinic with performativity. Jameson's (1984) reading of Lyotard's work contrasts the received view on scientific enquiry with that which a perspective in which

> the justification of scientific work is not to produce an adequate model or replication of some outside reality, but rather simply to produce *more* work... (italics in original) (p. ix).

Constructing encounters around the 'presence' of competing health messages serves to accomplish positions for members in relation to performances enacted in the clinic. Performance involves 'clarifying' competing messages. The nurse's aim is that of ensuring her message is 'heard' above other competing messages. This interpretation of action in the clinic emphasizes a view of nurses as knowledgeable performers who demonstrate considerable skill at actively constituting 'viable interests' in encounters with clients. The performance draws on sophisticated mechanisms for positioning themselves and others in particular ways. The aim is to excavate these 'ways' as they are deployed in practice.

3.3 "Associations" and differentiating messages

In light of this excursus into Lyotard's thesis on language games, the discussion now turns to re-examine the positions and moves accomplished between Helen and Paula at the home visit. Paula's announcement of the doctor's instruction to begin feeding the baby is taken by Helen as 'incorrect'. Pausing long enough to 'hear' Paula's own reservations about the doctor's message, Helen constitutes an "association" (Latour, 1986) with Paula. The crucial point for Latour is that an investigation of the ways in which actors mobilize associations towards one another, makes available to the analyst "another type of explanation" (p. 277). The analyst can

> use all the forces that have been mobilised in our human world to explain why it is that we are linked together and that some orders are faithfully obeyed while others are not (Latour, 1986, p. 277).

Paula's judgment of the doctor's message as incorrect advice has been constructed by Helen as aligning with the official position of the clinic. The association is reinforced with Helen's 'acknowledgement' that, as clinic nurses, they 'understand' the parent's position with regard to other professional and lay messages as being one of opposition: the parent is constituted as having come "up against" competing messages. The mobilization of associations performed by Helen have significant implications for Helen's position which is one of getting

Paula to follow 'official clinic advice'. The image of power as that exercised by certain members which influences the actions of other members is underlined on this reading.

Associations between the clinic and parents in the community are accomplished through talk and this work begins early in the relationship between the parent and the nurse. It represents a condition for continued contact with the clinic. The association which nurses at the clinic aim to establish is one in which, amidst competing messages which parents are "up against" in their day-to-day contexts of caring for children, the message from the clinic is the best. 'Best' too, is contextualized by the nurses.

During final interviews nurses accounted for their work as being 'specialized' in particular ways. For instance,

> Fran: I think it's great, the immunization clinics you know, at two, four, six months we're getting to go through all this nutrition stuff and we do have way more time than physicians to go through some of that stuff and sometimes I think we have more practical stuff. Like it's fine for a physician to say "Yeah, you can start doing solids and these are good foods" but it's nice that there's a place that they can come and say "This is *how* you make baby foods" and more the hands on, how to do it stuff. Like a lot of doctors are great about saying what kind of formula a person should be on but ask him how you clean bottles and how you make your own formula and that sort of thing ... it's just more practical, not more useful, it's just useful in a different kind of way.

Fran describes what is 'good' about messages given in the immunization clinic. Clinic nurses are said to "have way more time than physicians" to instruct parents regarding feeding regimes. The message is said to be "more practical ... more hands on, how to do it stuff". First claiming that the information is "not more useful", Fran then states that it is "useful in a different kind of way". This "difference" is important for the nurses. By constituting their work as 'different' from other health care workers they create a space for claiming priority for the message they give in the clinic. The nurse's discursive work of 'marking' territorial spaces, that is, creating discursive spaces, has an effect on the position she takes towards clients. If Lyotard is right, messages sent from this position will displace others in particular ways. The effect of constituting the clinic within

particular spatial arrangements in this way is to create conditions upon which 'moves' can be made. This 'action' then, again points to the knowledgeable deployment of strategies for establishing grounds within which practice can be conducted.

For now, I want to re-iterate the argument put forward thus far which is that by marking the clinic as a location where particular types of information about child rearing can be obtained, nurses constitute a 'context for talk' in the clinic. The context represents the active accomplishment of 'discursive spaces' and offers possibilities for performances as 'practice'. The clinic counselling session represents a locale where typical, day-to-day concerns about child-rearing can be raised and where "practical, hands on" advice can be obtained.

3.4 Contextualizing talk in the clinic

Members encounter one another then, within a context of 'competing messages'. While analytically it is of some benefit to think of 'context' and 'members' as though they were separable, in order to move on in the analysis it should be recognized that *as context* and *as members* these aspects of the day-to-day organization of the clinic are irremediably connected. The discussion now turns to highlight the conditions underpinning the association of members in the context of the clinic. The discussion shifts briefly to explore Giddens' development of "locale" (1984, p. 118) as this provides a perspective for understanding the ways in which discursive strategies for constituting context impact work in the clinic setting.

Giddens claims that locales are

> typically internally *regionalized*, and the regions within them are of critical importance in constituting contexts of interaction (Giddens, 1984, p. 118, emphasis in original).

This formulation of locale points to the implications of time-space dimensions on encounters taking place within a setting such as Hillcrest Clinic. As argued above, clinic visits are grounded in a discursive space of 'competing messages'. A discursive space may be understood in terms of a "facility" (Giddens, 1984, p. 29) for members in the clinic to make access to one another for the purpose of conducting particular sorts of encounters. These encounters are "regionalized"

in space and time. As such, practices are affected in particular ways by the locales which frame them. This is an important point and will be explicated further.

Giddens develops the notion of regionalization to contrast with the widely accepted connotation of region as merely a 'geographical space'. For Giddens,

> 'Region' ... as used here always carries the connotation of the structuration of social conduct across time-space (1984, p. 122).

Thus, regions are understood as interpenetrated by meanings, moral orders and aspects of domination. The effect of this interpenetration is to discipline social conduct within the region.

The organization of interactions occurring in the clinic are 'informed' by the space and time implications of such regionalizations. For instance, the immunization given to the child is understood, by the nurse, as the final aspect of the visit. In the process of re-ordering her desk in preparation for the next visit, the nurse 'signals' to the parent that the visit has ended.

Social actors who make 'readings' of the context as both organized and organizing are, in this way, informed regarding appropriate conduct in the setting. Recognizing the visits as "pretty much the same as last time" is productive for the parent as such recognition rests on their previous readings of organized activity and informs present understandings of activity in the clinic.

Once they have moved into the clinic room, parents prepare themselves to respond to the nurse's questions just as the nurse prepares herself to listen to the responses. Having 'read' the clinic, having been 'moved' by the language game in play there parents are positioned, not only by the person of the nurse but also by the materiality of the nurse's work place as a regionalized locale. In this sense then, one can speak of parents as 'displaced'. Such displacement is *felt*, it is an experience in the bodily sense captured by Ondaatje in The English Patient (1992), and reflected in the epigraph to this chapter. I would add to Ondaatje's quote that displacement is experienced as 'a consuming of oneself and the past' in the present and, in turn affects future conduct.

I advance a specific framing of the term 'obligation', an effect of the displacement of the language game operating in the clinic. By obligation I do not

wish to point to some psychologistic schemata to 'explain' the behaviour of individual participants. Rather, obligation, as it is used here, refers to the outcome of mutual work by participants, facing one another within organized, contextualized settings. That effect is felt bodily, as a displacement, and, following Lyotard and Giddens, obligations constrain (but also enable) participants to talk in particular ways. Displacement of this type arises from readings made by members of socially constructed regionalizations of clinic, constituted in part by a discourse of 'competing messages'.

4.0 Images of work: calling parents to account

Two particular images of work are evident. First, that image of work whereby parents are called to account for the care of their child. Second, that image of work whereby nurses attend to the account in order to 'assess' it in relation to circulating messages regarding health and, where 'necessary' to adjust the message constructed within the encounter.

4.1 Instantiating the obligation to talk

Accounts of parenting are encouraged by nurses at the clinic. In the following example nurse Diane makes four attempts to get talk going with mother Sandra early in an immunization clinic visit. James, Sandra's five year old boy has come to the clinic with his mother, and two friends of James' whom Sandra is baby-sitting for the day.

Sandra talks to the children and asks them to settle down and sit in the corner of the room. Sandra sits opposite Diane and James stands close beside Sandra.

Diane: (6.0) Well, uhm I'm ... my name is [Diane] (2.0) and uh, is there ... are there any concerns that you're /

Sandra: / No /

Diane: / having with [James]?

Sandra: No.

Diane: No? Everything's going well?

Sandra: No, I think so, yes.

Diane: Good.

Child whispers to Sandra. Diane sorts out a few papers on the desk in front of her while watching Sandra and James talking.

Diane: (10.0) **(whispering)** What? What did you say?

Diane leans over towards the child on Sandra's lap and smiles. Then Diane passes the height and weight graph over to Sandra.

Diane: You can keep this. There's a few weights on there, just up to two years.

Sandra: Oh, is there? OK.

Diane: Did you want to see where his-s-s weight is on there?

Sandra: Oh, that would be interesting.

Sandra's rapid responses to Diane's questions, demonstrated by the overlapping conversation, underlines her displacement and the resulting 'obligation' to provide answers quickly. Sandra may have 'read' the context of the immunization clinic interview as one offered by health professionals to provide assistance to parents in need of help. If Sandra does not see herself in this group, that is, as a 'needy parent', she will want to take as little of Diane's time up as possible. As an effect of regionalization, this interpretation attends to the influence which reading the 'regionalization' of the clinic has on Sandra's conduct.

Diane operates under a very different time frame from Sandra. As an experienced practitioner in the clinic, Diane 'reads' the move to the clinic room as the commencement of a twenty minute immunization clinic visit. For Diane, time is not contingent on 'need'. Counselling sessions, as a 'conventional' aspect of work in the clinic, are organized by staff members to last fifteen minutes with five minutes at the end of the 'counselling' segment to accomplish the immunization. Staff members take such an understanding of the move to the clinic room for granted.

In practice, it is more difficult for staff members to account for giving *less* than fifteen minutes during a counselling session. In an interview with the researcher, Diane commented on the previous evening's immunization clinic:

Diane: Hot yeah ... and then if it's, you know, I usually end up going through all the areas until you find out that there really is no problem ... last night I didn't even do that. It was just too darn hot!

Diane indicates that only by using the temperature of the clinic can she account for not "going through all the areas". There are no 'professional' grounds on which such a claim can be advanced. Earlier in the interview Diane stated that parents attending the evening clinic had been irritable. She 'decided' not to keep them unnecessarily at the clinic because it was so hot.

During day-time clinics when the clinic manager is 'present' (although frequently away from the clinic at meetings in other locations), three or four staff members work at each clinic. Receptionists 'feed' clients in at a rate consistent with the twenty minute time slots. The 'presence' of the manager during day-time clinics stands as an example of the interpenetration of systems of domination, legitimation and signification, on the conduct of staff members. The twenty minute counselling session might be very uncomfortable if the nurse cannot encourage the parent to talk. As the scenario between Diane and Sandra unfolds, Sandra apparently revises her original reading regarding the move to the clinic room; a topic which Sandra finds "interesting" represents a relief not only for the nurse but also for the parent.

Parents, as consumers of the service, operate under an obligation to get something out of the visit, to 'appropriate' meanings from the visit. The nurse-client association means that parents are 'given' responsibility to produce talk: their consumption of the association produces talk. The association also has implications on the nurse's potential for exercising power in the encounter.

4.2 Talking it up: chat work in the clinic

Once the ground for talk has been cleared, that is, once the parent is 'cued' to provide an account, even if, as in the preceding example, this is merely an indication of 'interest' in a topic raised by the nurse, work for the nurse is possible. In keeping with the 'friendly' atmosphere of the clinic, particular forms of talk are privileged by staff members.

As a strategy influencing the production of accounts in clinic encounters, 'keeping it light' appears to off-set what are constituted by nurses as inherent 'dangers' in the practice relationship. Nurses were observed to use a number of techniques to keep the interaction 'light'. In the following interview excerpt Diane recalls making use of the technique of what might be described as 'clarification of non-verbal activity' in order to lighten up the encounter:

> Diane: Like this morning I had a mother in that when she was in the waiting room she looked really grumpy? A young, cute little mother **(laughs)** and actually, my first gut feeling was "Yuck" you know, negative. And when I got her into the room I finally after talking to her for a while I realized, she was like that because she was so worried about getting the immunization like here she had been through like three DPT's and her little one year old was going to get a measles, mumps rubella and uh, so when I discovered, after *that* I said to her, "Oh, is that why ..." something about the face she had on in the sitting room and then she just lightened right up! You know, and then actually she was talking more about her little daughter after that. *And*, not only that but then she started saying nice things about her daughter.

This excerpt describes an encounter in which the mother's facial expression was 'read' by Diane as indicative of someone in a bad mood: "she looked really grumpy?". Diane's account suggests that parents may be 'sized up' by nurses in the waiting area and, based on the impression given there, the nurse gains a sense of how the encounter itself might be expected to proceed. The opportunity to make 'readings' in the waiting area should be understood as an effect of the regionalization of space in the clinic as a whole.

The account provided by Diane is directly suggestive of Goffman's analysis of impression management (1959). Goffman claims that social actors expect or perhaps, take-for-granted, a "confirming consistency between appearance and manner" (p. 35). Diane's account suggests that such consistency was lacking: "she looked really grumpy? A young, cute little mother **(laughs)** and actually, my first gut feeling was 'Yuck' you know, negative". The account points out a difference noticed by Diane between the "grumpy" manner observed in the waiting room and the "young, cute little mother". Ideally, mothers who in

appearance are young and cute would not normally be expected to have a grumpy manner.

Goffman suggests that an inconsistency with an

> ideal type (provides) a means of stimulating our attention to and interest in exceptions (1959, p. 36).

Diane's response to the "exception" represented by the inconsistently "grumpy" manner of a "young, cute little mother" suggests that she read the signs given off in the waiting room as potential danger signals. Diane has had advanced warning that this particular mother-child pair represent an exception to the ideal type. Anticipating a problem, Diane's account reflects a strategic deployment of her conversational technique. A legitimate reason for the inconsistent manner is offered ("because she was so worried about getting the immunization") to the parent in order to 'guide' (and, in light of the argument which is to follow, guiding should be read as instructing or disciplining) the parent toward a manner more consistent with her appearance. This has the effect of "lightening up" the encounter, enabling the nurse to proceed, now as though the parent were again an "ideal type".

This technique was observed to be used across practice locations. In the following example, taken from observations at a Senior's Drop-In clinic, Jill used a technique of 'rehearsing reality' as a way of 'keeping it light'. In the following excerpt she employs this technique with senior's resident Doris. Doris has explained to Jill that she has recently had a blood test. The test indicated that her present medication is not effectively keeping her blood sugar level within a 'normal' limit:

Doris: And it has been most of the time fifteen. But now it's not coming to fifteen I don't know what to do with /

Jill: / It went *down* a little bit then last time.

Doris: Yeah, and now today she's taken my blood again /

Jill: / again, yeah.

Doris: I don't remember exactly ...

Jill: Well, (2.0) I don't ... this ... I'm just thinking, the ... (3.0)

Jill turns away from Doris and touches the blood pressure cuff which sits on the right hand side of the desk. She moves it slightly on the desk surface. Doris watches Jill's face attentively.

Jill: Uhm **(sighs)**, you *worry*, and there's nothing much you can do about it /

Doris: / No /

Jill: / you know, and the worry if anything just puts your blood pressure up or makes ... bothers you, uhm, the thing is you're taking good care of yourself. You come down here and have your blood pressure taken and you've got a nice doctor, she's working closely with you.

Doris: Yeah she works ... /

Jill: / And she understands you.

Doris: Yeah. Because I have been a patient for many years.

Jill: Yeah, so, uh you're doing as much as you can.

Doris: Yeah, that's it.

Jill: So, (2.0) it's easy for me to say not to worry but you know, just maybe *relax* a little bit. Some people, you might even have to get used to the fact that maybe your blood sugar and your blood pressure is going to be the kind that zig-zags up and down, you know. Like this.

Jill demonstrates an up and down motion with her right hand.

Jill: And even if you *had* to go on ... insulin, ... uhm, (2.0) what can you do about it anyway? Uhm, you know ... you watch your diet and /

Doris: / yeah /

Jill: / if that's the way it has to be that's the way it has to be, you know? Uh, everybody's pancreas works differently ...

Following Doris' account of the problem, erratic blood sugar readings, Jill is initially at a loss for words. Her halting utterances and distracted actions of moving the blood pressure cuff suggest that she has heard Doris but is, for a moment, unable to provide a response. The three second silence is followed by a

series of utterances however, which act to 'guide' (instruct, discipline) Doris towards a 'lighter' view of her present state of health. Jill acknowledges Doris' feelings, she points to the "close" relationship between Doris and her physician, and then suggests that this represents the limits for action: "you're doing as much as you can".

This series of utterances transposes Doris' hopelessness through the construction of an alternative, 'lighter' version of her state of health. The instability in Doris' blood pressure and blood sugar are normalized. Doris is 'instructed' that she might "have to get used to the fact" that her body can no longer be relied on to be stable. Finishing on a 'lighter note' that "if that's the way it has to be that's the way it has to be", Jill positions herself by displacing Doris' concern. No.w, they may move on to another topic.

The strategy of 'keeping it light' increases performativity in the clinic. Strategically deployed, it re-orients clients, positioning them in relation to the nurse so that accounts can be sought but quickly moved through at a pace which the nurse maintains control over. 'Keeping it light' facilitates rapid movement from topic to topic. It allows the nurse to undertake a spot-check type of survey of the developmental status of a child in the immunization clinic or to avoid what are treated as irremediable problems associated with ageing in the Senior's clinic.

5.0 Images of work: auditing accounts

The production of accounts, as these examples demonstrate, not only position the client as the member with an obligation to account but also positions the nurse to attend to these accounts. In this way, the language game is productive for nurses: as strategies for producing accounts in the clinic, they serve to produce work for nurses. The discussion now turns to outline the nature of this work.

Positioned within a context informed by a discourse of competing messages, there is a sense in which accounts generated by parents (facilitated by the nurse's discursive strategies for 'keeping it light') contribute to

performativity in the clinic. Once accounts have been generated, nurses treat these accounts as occasions to 'do nurse' (see Garfinkel, 1967).

5.1 Opening up accounts

Once accounts are forthcoming from clients, the nurse changes tack and, instead of working to generate talk, she 'audits' the talk generated. As an example of how the nurse enacts this aspect of her work the following encounter between nurse Diane and mother Molly in the immunization clinic is offered.

Molly and Diane have been discussing four month old Sam's sleeping and eating habits. Molly has indicated that she has been breast-feeding Sam since birth and has no plans to begin introducing solid foods until Sam is at least six months old. A policy framing instructions given by nurses at the clinic was that breast-fed children should be given vitamin supplements until such time as they begin eating a wide variety of foods. When formula-feeding had been chosen as the preferred feeding method, parents were typically advised not to give extra vitamins as there were said to be sufficient quantities added by manufacturers of prepared formulas. As Molly was a breast-feeding mother, Diane would be expected to advise the supplementation of vitamins for Sam's diet. However, as the following short excerpt indicates, in this instance Diane does not follow the policy guide-lines:

Diane: OK, do, do, you don't, do you give vitamins?

Molly: No, I don't yet ... but I eat really well.

Diane: OK.

Molly: (3.5) And I have the fluoride, I haven't been giving him fluoride.

Diane: (2.0) Is it just a matter of remembering ... or half for it?

Molly's three and a half second pause can be read as an instance of obligation to talk: Diane is waiting for an 'account' from Molly further explaining her decision not to give the baby vitamins. Molly 'refuses' further explanation by shifting to the topic of "fluoride". The 'shift' represents what Lyotard describes as an "unexpected move" (1979/1984, p. 16). Rather than allowing Diane to raise the

topic of fluoride, Molly does this herself. Having 'usurped' the nurse's position in the making of this novel move, Diane is temporarily displaced. The two second pause between utterances gives some indication of this. Diane sends her message about fluoride from a different position than if she been able to ask the question about fluoride herself. Having already heard, that is, audited, Molly's account that she has fluoride but does not use it, Diane asks her question from a position of having to find out why this is so. Molly has increased the gradient operating in the encounter. By displacing Diane as a result of a novel move, Diane now engages in verbal work to regain her position.

The encounter continues for several more turns during which time a discussion of general dental hygiene takes place. Finally the topic of fluoride re-surfaces. As an alternative way of introducing fluoride, Diane asks whether Molly uses fluoridated toothpastes. Molly responds affirmatively and Diane then states, in the form of an instruction:

Diane: That does a lot of good too.

Molly: Yeah, well, for my *daughter* ... but I don't think that it helps adults at all. Because like I have a, a girlfriend who's a dentist and she said after you're about sixteen, once your teeth set /

Diane: / um hm-m /

Molly: / fluoride doesn't really help you very much. Like where I get my teeth cleaned and that? I never get the fluoride.

Diane: You don't.

Molly: Um m-m-m, no never.

Diane: Well for children, just keep on using it for your daughter and your /

Molly: / yeah /

Diane: / son /

Molly: / well maybe I'll start giving him fluoride after I can maybe stick it, and dilute it in some food or something like that.

Diane: Uh hm-m-m ... usually, if you are planning on giving it, it's best to give it with water /

Molly: / water? /

Diane: / or juice /

Molly: / yeah? /

Diane: / that type of liquid as opposed to milk or other foods /

Molly: / yeah? OK ...

Diane: It's most completely used.

Molly is rubbing the baby's head.

Molly: I bumped his head. He's got this little red spot here.

Diane: Oh! I missed that. I thought that was just a little ... birth mark.

As a measure of the nurse's domination in these encounters, Diane's return to the topic of fluoride again is significant. Molly has previously indicated that she is "against" giving fluoride because she considers it a chemical and does not want to introduce chemicals into her child's body. Operating from her dominant position in the encounter, Diane makes the new move of suggesting an alternative form of giving fluoride to children, "fluoridated toothpastes". Drawing on the context of competing messages, Molly counters Diane's move by referring to her friend, identified as a dentist. Again Diane is displaced from her privileged position as counsellor.

This latter move demonstrates clearly the interpenetration of structures of signification, legitimation and domination. The friend's message, legitimated as an expert by virtue of her label "dentist", has meaning and exerts influence in the encounter as Diane's displacement suggests. The effect of Molly's assertion regarding the importance of her dentist friend's message about fluoride moves Diane to the extent that she now alters the referent of her message. Rather than advising that the whole family might benefit from fluoride, she suggests that Molly "keep on using it for your daughter and your son". The change in Diane's message reflects the extent to which she has been moved around by Molly in this language game. However, it also reflects the extent to which her conduct takes

account of the obligation to attend to Molly. Diane's 'audit' of the account facilitates her ability to play the language game.

In keeping with an agonistic view of language, Diane's next move is subtle but representative of a "good move" (Lyotard, 1979/1984, p. 16). Picking up on the opening in Molly's message, she turns it to her advantage. While conceding Molly's point that "after you're about sixteen" fluoride is no longer useful, Diane makes Molly's two children, both under sixteen years of age, the referent of the next message: "for children, just keep on using it for your daughter and your son".

Now Molly is displaced, moved by Diane's assertion. Molly makes a "reactional countermove" (Lyotard, 1979/1984, p. 16): she concedes to giving her son fluoride once she can dilute it in food. This may be an attempt to 'stave off' having to follow Diane's advice for some time as she has indicated that she plans to continue breast-feeding for at least another two months.

The advantage taken by Diane when making the final move demonstrates her position of domination in this encounter enabling her to reinforce her message. Diane instantiates the clinic as the location of the 'best' health information by instructing Molly that "if you are planning on giving it, it's best to give it with water". Molly had previously indicated that the baby has been taking a bottle of water at least once a day. Molly is suddenly in a much less powerful position from that attained through her initial displacement of Diane.

Significantly, Diane does not seek verification that Molly will in fact give fluoride to baby Sam. It appears sufficient that the instruction has been given. The game has been played and has resulted in Diane accomplishing her 'instruction'. There is no further follow-up: the conversation moves swiftly on to a discussion of "marks" on the baby's skin.

5.2 Obligations and strategic conduct

'Audit', as it has been illustrated in the preceding example, reflects what Giddens refers to as "strategic conduct":

> In the analysis of strategic conduct the focus is placed upon modes in which actors draw upon structural properties in the constitution of social relations (Giddens, 1984, p. 288).

As this definition implies, the aim, having identified 'audit' as an example of strategic conduct, is to situate this conduct within larger structures informing practice in the clinic. What have been described as 'obligations', reflect embedded orders of knowledge informing conduct at a much deeper and extensive level than merely 'conventions' for conducting conversations. I have pointed to the interpenetration of structures of legitimation, signification and domination in the preceding example. The aim in the following chapters will be to demonstrate how "modes" of practice, apparently operating at the surface, are influenced by "structural properties in the constitution of social relations" (Giddens, 1984, p. 288) in the community clinic.

For instance, discursive strategies, in addition to framing the meeting, accomplish mobility (as in the case of 'keeping it light') facilitating rapid, survey-like overviews of pre-specified agenda topics. These discursive strategies are, at the same time, drawn on by clients who make use of them to 'appropriate' cues issued by nurses in order to produce accounts.

At the level of day-to-day practice, nurses work at generating talk within the context where 'accounts' are treated as necessary pre-requisites for work. Based on 'auditing' these accounts for openings, nurses are enabled to offer 'instructions' to the parent. There is a strategic aspect inherent to this expert, linguistic work. In the clinic, expertise relies on a 'store' of appropriate instructions, based in a discourse of 'research-based knowledge' or managerial demands for 'standards of care'. However, I would argue that such explicit 'knowledge', available in policy manuals and professional journals, is insufficient *on its own* to account for the mode of practice enacted in this particular setting. While in the policy manual, nurses are advised to tell all parents that vitamins are to be given to all breast-fed children, this 'knowledge' is enacted within a contextualized setting. The text of the policy is 'translated' during the language game and is strategically deployed in the encounter. The translation is not always accomplished 'perfectly'; aspects are added or drop off. Some explanation for this phenomena must be given.

Performative aspects of the language game engaged in by members come most crucially to the foreground. The game does not merely rely on an

authoritative power, a power imposed by the professional on the lay person, a power arising from a position of greater knowledge. Rather, the game relies on the tactical construction of an intervention based not only on 'knowing' but also on 'hearing' the possibilities provided in talk.

6.0 Summary

Opportunities for work in the clinic are secured through the knowledgeable reading and introduction into the encounter of structural properties framing social conduct in this particular, regionalized practice setting. Having identified what the practice relationship 'looks' like at the surface, the aim now is to excavate further to explore the nature of the structural properties informing this particular mode of practice.

In this chapter I have been concerned with demonstrating the dominance of 'talk' at Hillcrest Clinic. As a mode for gathering information (that is, assessment) upon which to base judgements (that is, interventions) talk might be treated, as indeed it largely is in other studies, as purely 'functional'. But in this sense, talk is merely the vehicle for doing something else called 'nursing'.

What has been raised in this chapter, taking account of the nature of language and social conduct, is the question of taking a step back and considering 'talk' as a social accomplishment and thus as influencing the conduct understood as 'nursing'. Members of the clinic, whether parents, nurses or children, it has been argued, talk in particular ways. These ways are influenced by readings made of the context within which the interaction is taking place. Context is understood not in a highly restricted way typical of much nursing research but rather as a *situated* context; context framed by time-space regions. In order to excavate the contextual influences on such talk then, these particular ways in which nursing in the clinic is conducted must be addressed.

The argument has been advanced that talk in the clinic is framed within a discourse of 'competing messages'. I have suggested that drawing on the discourse of competing messages, members are 'positioned' to talk in order to fulfil obligations in the encounter. The 'presence' of competing messages emerging in an encounter between a nurse and client represent opportunities for

nurses to constitute discursive spaces: accomplishing discursive space contributes to the creation of conditions upon which 'moves' can be made.

'Roles' constituting the practice relationship at Hillcrest Clinic have been demonstrated to be, at times, blurred. For instance, termination of the visit was observed to be 'negotiated' through readings in the regionalized space of the clinic office. Sometimes the nurse asserts her dominant position in order to complete the visit. Typically such assertion of role was not required; that is, most parents 'read' it 'right'. We might say they 'knew' when the session was complete. Inferences such as those involved in 'reading' the clinic, reflect the outcome of some considerable interpretive work (cf. Eco, 1984).

It has been argued that the 'obligations' to talk and to listen reflect the outcome of parents and nurses making readings of one another as well as the spaces and times in which they encounter one another: 'obligation' reflects interpretive work based on those readings. The question which follows then is, if parents are being 'called to account' by nurses in this setting and if, as a result of the call to account the nurse listens to the account, it must be asked what kind of accounts are these and what kind of listenings?

What I am pointing to is the notion that 'talk' as it is enacted in this setting can be investigated as 'disciplined' and 'disciplining' (Foucault, 1975/1977). The foregoing examples suggest that members encountering one another in the clinic approach talk from disciplined positions, that is, 'knowing' somehow *when to talk* and when not to. Additionally, I would argue, these members demonstrate an intricate competence at 'knowing', not only how to talk in a general way, but *what to talk in particular ways.*

CHAPTER SEVEN

Measurement Technologies:

transforming the body

> I should like to attempt here the analysis of a type of discourse ... at a period when, before the great discoveries of the nineteenth century, it had changed its materials more than its systematic form. The clinic is both a new 'carving up' of things and the principle of their verbalization in a form which we have been accustomed to recognizing as the language of a 'positive science'.
>
> M. Foucault, The Birth of the Clinic, (p. xviii)

1.0 Introduction

In the previous chapter, extracts of 'conversations' in the clinic were examined as instances of 'strategic' conduct. I have argued that, as strategic conduct, members draw on material aspects of the clinic life-world to constitute relations in the clinic. It was argued that a discursive space of 'competing messages' facilitates members abilities to displace one another, thus representing an important aspect contributing to the constitution of relationships in the clinic.

In this chapter typical conduct observed and recorded in the clinic will be explored in greater detail. Examining the way in which the practice relationship is 'set up' by clinic members, the argument will be advanced that nurses' constitute the child's body and the parent-child relationship in particular ways which not only influence the constitution of the nurse as an 'expert' but also have wider implications for the way in which messages are transmitted during the counselling segment of the encounter.

1.1 Setting up work in the clinic

In the preceding chapter it was suggested that the measurement of children attending the clinic is treated by members as a 'pre-requisite' for 'counselling'. In this chapter this aspect of the visit, the taking of measurements, will be explored more fully. I will argue that nurses draw on measurement technologies to transform representations of the child. For the work of the clinic to proceed, it is important for nurses to get the 'right' forms of representation.

Developing the analytic language outlined in the previous chapter, I will argue that transforming the representations of the child involves, to a significant extent, displacement of alternate representations of the child. That is, representations of a child held by parents are 'managed' in systematic ways by nurses so that a particular, technical version can be advanced during the counselling segment.

1.2 Foucault's concept of a disciplinary 'gaze'

The notion of a disciplinary 'gaze' arises from Foucault's wider project, but for the present, his ideas articulated in The Birth of the Clinic (1963/1973) are most apposite. Foucault argues that perceiving and knowing are not only formulated by 'perspectives', but that the structures actors draw on to *gain* perspective are themselves framed and shaped by notions embedded in language. For Foucault, these deeply embedded notions are understood to have had extensive effects on modern society: these features of language have shifted understandings of what it is possible to 'know' and 'see':

> ... we are concerned here not simply with medicine and the way in which, in a few years, the particular knowledge of the individual patient was structured. For clinical experience to become possible as a form of knowledge, a reorganization of the hospital field, a new definition of the status of the patient in society, and the establishment of a certain relationship between public assistance and medical experience, between help and knowledge, become necessary; the patient has to be enveloped in a collective, homogeneous space (Foucault, 1963/1973, p. 196).

Foucault links 'experience' of clinical matters, as a "form of knowledge" with wider reorganizations of relationships amongst social members situated in

particular locations. The social conditions were 'right' to enable "clinical experience to become possible as a form of knowledge". The implication is that previously, because these conditions were not 'right', clinical experience of the sort which gave rise to medical science, was not "possible".

From this position, two central question are addressed in this chapter. First, in what ways are the representations of children attending the clinic transformed by nurses, that is, how is the clinic visit treated as a 'clinical experience'? and secondly, what are the conditions facilitating such a transformation? Following Foucault, the nature of this transformation can be expected to be in line with the desire to make the child's body objective and visible.

> It was also necessary to open up language to a whole new domain: that of a perpetual and objectively based correlation of the visible and the expressible. An absolutely new use of scientific discourse was then defined: a use involving fidelity and unconditional subservience to the coloured content of experience--to say what one sees; but also a use involving the foundation and constitution of experience--showing by saying what one sees (Foucault, 1963/1973, p. 196).

Foucault points to what he takes to be a firmly established link between language and visibility in the constitution of experience; a link which he then proceeds to critically examine. It will be recalled that in chapter four [p. 105] reference was made to Foucault's position that the visual metaphor represented only one of several principles governing technologies of power in modern societies.

The concern for early medical 'scientists' to objectify experience took place by drastically altering the relationship between knowledge and visibility, that is, showing by saying what one sees. Foucault's crucial point is not that the eye comes to see more clearly, that is, more scientifically, with the advent of medical science, but rather that the forms of representing what was seen *were themselves* transformed, through linguistic means, to suggest clarity of vision. Of particular interest in this chapter is not merely demonstrating the pervasiveness of this effect, which Foucault's writings already alert us to, but towards an examination of the particular effects this 'clarity of vision' has on conduct in the clinic.

1.3 Analysing 'visibility' in the clinic

The analysis of conduct begins, from a position which takes action and understandings of action to be socially constructed. The means by which clinic encounters are given definition by the social actors involved in constructing them are of fundamental interest.

Taking direction from Latimer's work (1993), three preliminary questions provide guidance:

1. What is visible during encounters between nurses and clients?

This is a two-part question. During the analysis of research materials undertaken for this study I have examined parent's accounts and nurse's accounts of the clinic encounter. This offers some indication of what was visible and thus accounted for during interviews with the researcher. However, I have also drawn on my own observations undertaken as part of the field work. I will reflect what was visible to me by comparing and contrasting my observations with accounts given by parents and nurses. In this way a triangulated account of practice in the clinic is accomplished. This approach to the research materials suggests two further questions regarding 'visibility':

2. What do the nurses make visible during their encounters with clients?

3. How do the nurses make these things visible?

Reference to 'the visible' world is used to address issues of analytic validity. The analysis upon which this interpretation is based draws on both observation and audio-tape recorded interactions between nurses and clients. Making the research materials available in this way, the reader is invited to enter into the world of the community health nurse, to reflect on the understandings of this world offered in the analysis.

The 'visible' is also used metaphorically to point towards a perspective taken during the analysis in which action-as-performance is central. Of particular interest are the ways in which performances enacted by social actors are implicated in transformations enacted during interactions. The aim of the

chapter then is to explore community nursing practice to explicate how and of what nurses accomplish transformations.

2.0 Disciplining the body: tracing change through measurement

Central to the 'work' observed in the clinic was the constitution 'change' since the last visit. The basis of this work of 'tracing change' will be explored in the following sections. The use of the word 'trace' is deliberate as the work engaged in by nurses is understood as that of attributing meaning to particular 'traces' inscribed on clinic forms during the parent's presence with their child at the clinic. This particular aspect of conduct, that of the parent bringing the child to the clinic, will be addressed later in the discussion as a significant 'move' in terms of the conditions facilitating practice in this setting.

The concept of change as it is used in the clinic typically implies a notion of 'progress'. 'Progress' can, however, be characterized as positive improvement or some sort of progressive deterioration. The claim I will advance in the following section is that the direction in which a child is said to be progressing represents the outcome of discursive work on the part of social actors in the clinic. In other words, the definition, determination and trajectory of change implies a constitution of transformation through linguistic mechanisms. Accomplishing such transformations, I will argue, represents a central aspect of conduct in the clinic.

2.1 Enrolling parents

Visits to the immunization clinic, as illustrated in the previous chapter, begin for parents and children, in the outer waiting area. There, they are met by a member of staff and the child's weight, height and head circumference are measured with a variety of instruments such as weigh-scales and tape measures.

These instruments are treated unproblematically by staff and parents. That is, what these instruments measure is never questioned. On two occasions the accuracy of the child's head circumference arose as a 'problem' during the counselling session. Otherwise, the accuracy of the measures were never called into question during observations of work even when the measurements were

used by nurses to construct 'problems'. The ways in which 'problems' enter the counselling session and their treatment there will be examined presently.

As noted in the previous chapter, the assistance of parents was enlisted by nurses during the measurement process. For instance, parents were asked to hold their infant's head leaving the nurse's hands free to fully extend the child's knees to obtain a measurement of length. Parents were asked by staff to hold older children who displayed reluctance at standing alone on the upright scales, the nurse later subtracting the parent's weight to obtain the child's weight.

The parent's position as 'assistant' was reinforced by a conventional practice observed whereby nurses made no direct reference to measurements obtained until parent, child and nurse were seated in the 'private' clinic room. Once there, introductions were made and the visit would 'officially' begin. The beginning of the visit was signalled, that is, made visible, when the nurse displayed the form upon which the measurements were recorded. This demarcation of practices underlines the act of measuring children as one of an entirely technical nature. In contrast, the *use* of the measurements during 'counselling' takes on an analytic function. During 'counselling', the technical is put to professional advantage.

A separation between the technical and the professional is signalled by the nurse's actions. While parents' active involvement is sought at the technical end of obtaining measures, their role in the office as passive recipient of the now professionally analyzed measures is announced. Through such discursive practices as these, parents and nurses are "positioned" (Lyotard, 1979/1984) in relation to one another. By treating the notion of 'role' with a degree of scepticism, actions such as these become significant for demonstrating the accomplishment of "asymmetrical" (Callon & Latour, 1981; Latour, 1987) relationships typical of those observed at the clinic.

For children from birth to two years of age, height, weight and head circumference measurements were plotted on a graph. The graphs had a series of curves printed on them, indicating percentile variations. Measurements taken out in the waiting area were transcribed by a nurse onto the percentile chart and a line drawn showing how the child's measurements had 'changed' since the last

visit. Change, then, is constituted in the clinic when the nurse 'shows by saying' what these traces of growth mean.

The following excerpt provides an example of how information about the percentile measurements is transmitted in a clinic visit. In this example, Bridget is the mother of a one year old boy called Ryan. Ryan is Bridget's first and only child. Jill, the nurse who measured Ryan in the waiting room has asked Bridget and Ryan to come to her office. Jill enters the clinic room first.

Jill: Just come on in and take a chair.

Jill points toward the chair beside the desk. She closes the clinic room door. Bridget begins talking as she sits down in the chair indicated.

Bridget: How does it go for his height and on that, does ...

Jill: How's he doing?

Jill now takes her seat. She has her hand on the blue graph which is laying on the desk beside her.

Bridget: Yeah, 'cause being a month premature I am just sort of wondering /

Jill: / M-m-m-m! /

Bridget: / if that has anything to do with it.

Jill: M-m-m-m! Generally when they hit about this stage, they're supposed to have caught up to the table, you know, to everybody else and it looks like he has done well from the very beginning. Uhm, so he's doing just great. He's on the twenty-fifth percentile and following that line, if you hadn't of told me, following that line of the twenty-fifth percentile, pretty well since birth. He was uh-h, just a little below and above it, just a perfect line there so he's doing great. As I say, if you hadn't told me that he was a month premature I would not have guessed it, you know?

Jill traces the line with her finger as she talks then looks up at Bridget and smiles.

Bridget: OK.

Jill: And as far as his height's concerned that's the tenth percentile and just you couldn't ask for anything more perfect than that and so that, yeah, that's just great.

The eagerness with which some parents approach the visit with the nurse is demonstrated. Upon entering the clinic room, Bridget constitutes her first experience as a mother as 'unusual' because her child was born prematurely. She mentions Ryan's unusual birth circumstances, accomplishing two aspects of the visit: to legitimate her eager request to know his weight and also to frame her question as something to be taken by the nurse as extra-ordinary. Ryan is introduced into the visit as a 'special child' by his mother.

Bridget's question to the nurse reproduces an interesting power relation. Under most circumstances, that is, beyond the boundaries of the clinic, Bridget might be understood to operate in a privileged position as mother to Ryan. As his mother, she might be expected to 'know' how her child is doing. However, as this example demonstrates, Bridget's privileged position is temporarily deferred, by Bridget herself, in favour of the nurse's position. Bridget's question instantiates the possibility that there are at least two versions of how Ryan is "doing": one, a private version, developed by Bridget within the confines of her personal life experience with Ryan and the other, a public version, constituted by the community health nurse based on a discourse of 'objective' and technical measurements. In the surroundings of the community clinic the mother's version is temporarily displaced in favour of the nurse's version. Bridget positions herself by representing her child in ways which are particular to the clinic.

Jill's response demonstrates how the construction of the child by the mother as a 'special child' has an effect on her position as the nurse. Bridget's rendering of Ryan as a 'special child' makes a *difference* to Jill. Jill must make an account of Ryan's 'special' category. She does this by stating that when children born prematurely "hit about this stage" they are expected to have achieved 'normal' measurements. They are expected "to have caught up to the table". Having heard Bridget describe Ryan as 'special', the focus of Jill's work is to normalize his development.

Jill indicates that Ryan has "done well from the very beginning". His measurements have been "following that line of the twenty-fifth percentile" referring to measurements taken at previous visits to the clinic. Jill reinforces a

particular view of Ryan's development which she is working at constructing: Jill tells Bridget that if she had not mentioned Ryan's 'special' status, Jill "would not have guessed" that there was anything unusual about him at all. 'Showing by saying what one sees', Ryan is constituted as 'normal'.

2.2 Making change visible

Pointing to the growth chart, that is, making visible to Bridget that Ryan's height and weight have been "following that line of the twenty-fifth percentile", Jill claims that Ryan's development is "perfect". In this case, the child's development is approved of on the basis of 'clinic standards': consistent measurements over time.

Claims for 'normal development', however, were observed to be inconsistent amongst nurses working in immunization clinics. For instance, in the following excerpt, the nurse, Helen, constructs 'abnormal development' of a child who is said to be too tall for his weight.

Ann holds her four month old son, Ken, in her arms. Mark, Ann's 2 year old boy, plays beside her. Helen leans forward, pointing to the growth chart as she begins to talk.

Helen: OK. This young man ...

Ann: Uh hmm /

Helen: / is a big boy.

Ann: Uh hmm.

Helen: Here's his, now I've put it in just that shade over the four months /

Ann: / yeah /

Helen: / and he's *ju-u-st* below the ninetieth percentile for length /

Ann: / uh huh /

Helen: / so he's *mo-o-oved* up tremendously 'cause he was just above average /

Ann: / Yeah /

Helen: / And his weight is just a bit below seventy-fifth so actually you can see that calorie growth /

Ann: / Yeah /

Helen: / has gone length-wise and he needs to fatten up a little. Eat a little bit more. Slow down his activity, whatever.

Ann laughs.

Helen: Yeah, sometimes that length will parallel off while the other /

Ann: / [Mark] was always tall, he was always up in the ninety ...

Helen: Yeah, well, he's certainly not underweight.

Helen glances over to where Mark is playing beside Ann's chair.

Ann: No, he's not suffering at all.

In this encounter, it is the nurse who takes the view that the baby, Ken, is in some way unusual. Helen builds her story in phases. First she points to the size of the baby in general terms by stating that he is a "big boy". Then, making specific reference to the measurements taken in the waiting area, she 'alerts' the mother to a 'problem'. Ken has "*mo-o-oved* up tremendously" since his last visit to the clinic. Previously Ken is said to have been "just above average". Now his height measurement is in the ninetieth percentile range. In contrast to this, his weight measurement is said to be "just a bit below seventy-fifth". Using numbers and measurements obtained out in the waiting room, the nurse builds a picture of Ken as a baby who has grown more than anticipated as well as having grown disproportionately. He is too tall in comparison to his weight.

Throughout Helen's construction of Ken's 'progress', Ann has responded with short positive utterances, suggesting perhaps that she is 'going along with' Helen's version of her child's development. She agrees that he is a big boy and that he has grown taller. However, when Helen advises Ann to take action based on the disproportionate 'progress' constructed, Ann's 'agreement' is withdrawn: she laughs in response to Helen's suggested intervention.

Ann's laugh following Helen's advice has a demonstrable effect on Helen's conduct. Helen is 'moved' by the laugh. Helen advances an alternative reading of the disproportionate measurements. Helen's concluding statement suggests that "sometimes" the measurements will become more equivalent without any particular intervention.

Helen's offer of an 'alternative reading' of the measurements then has an effect on Ann. Ann points to her older child, Mark, who is playing beside her on the floor. His height measurements are said by Ann to be similar to those of the baby she is holding on her lap. Measurements for one child, the object of the measurement technology, are transposed by Ann as though, for her, they have meaning for her older child.

Two points can be examined further. First, claims to objective, secure 'knowledge' in the clinic are not beyond question. The point raised earlier about the 'taken-for-grantedness' of measurement technologies can be picked up again.

Treating measurements as 'secure' facilitates the nurses' work in the private clinic room. Based on measurements taken in the waiting room and inscribed onto the weight and height graphs, nurses construct particular relations between the numbers and how the child brought into the clinic is to be represented for the purposes of the clinic visit. Over time, the measurements and their inscription on the graphs come to be taken-for-granted by the nurse; she treats these as though they represented 'knowledge' about the child upon which work in the form of 'instructions' might be based.

Callon and Latour (1981) describe this type of 'knowledge' as being based on premature 'closure': knowledge about measurements is, for the nurse, located in what Callon and Latour call a "black box". Black boxes are constructed by "associating materials of different durability" (p. 284). The result of such associations is that

> a set of practices is placed in a hierarchy in such a way that some become stable and need no longer be considered (Callon & Latour, 1981, p. 284).

By placing a set of practices, such as those broadly grouped under the category of 'measurement technologies', into boxes as 'orders of knowledge', taken-for-granted as stable and meaningful

> an actor grows with the number of relations he or she can put, as we say, in black boxes (Callon & Latour, 1981, p. 284-5).

As the previous example of the interaction between Helen and Ann demonstrates, Helen's size as an actor in the clinic is quickly deflated with Ann's laughter. Prior to Ann's laugh, Helen was positioned to give instructions. Following the laugh this position has changed and now Helen must 'account' for her numbers in a different way. Her black box has "leaked" (p. 285), as Callon and Latour describe it, and her size as an actor within the clinic alters as a result.

The point is that the effect of placing knowledge about measurements into black boxes 'facilitates' practice. That which is located in the black box does not have to be examined each and every time. The crucial point Callon and Latour raise about 'black boxes' however, is that they are not as secure as actors assume. They 'leak' as in the example above. The effect of the 'leak', in this case, accomplished through Ann's laugh, is to position Helen in such a way that she 'revises' her previous instruction.

A second point about measurements is that, although the 'leak' has a demonstrable effect on Helen's relative size as an actor in the clinic, it is important to notice what else is accomplished by Helen's move to account for her prior instruction. Refusing any revision of the measurements, which remain after all, the source of her 'instruction', Helen suggests that sometimes, without any alteration in the care of the child, the measurements will 'rectify' themselves. Ann's laugh in response to Helen's initial instruction is read by Helen as a signal that her measurements (that is, 'the technical') may be under attack. Technical actions implicated in the obtained measurements remain buried in the black box because of Helen's suggestion that "sometimes" without any intervention on the part of the parent or, apparently, the nurse, the child will develop 'normally'. Willing to risk her reputation as an expert, it is important to note that Helen's response underlines the extent to which measurements are embedded in understandings of work in the clinic.

Helen's willingness to defer on her own instruction must be treated within the wider context of expertise as not merely an effect of individual actions. Rather, expertise in the clinic relies on networked relations between clinic personnel, the materiality of their life-world and those who enter the clinic as service recipients. These relations will be explored next.

3.0 Making connections

As part of his theoretical explorations of semiotic transformation, Eco (1976) claims that,

> a transformation does not suggest the idea of natural correspondence; it is rather the consequence of rules and artifice (p. 200).

This view of transformation is consistent with Callon and Latour's notion of the black box. Callon, Latour and Eco draw attention to the pervasive effect which connections such as those between the inscriptions made on clinic forms and 'development' have on interaction in the clinic. Eco reminds us that transformations accomplished on the basis of such connection arise as a "consequence of rules and artifice".

Eco's reference to "artifice" should not be taken lightly for it stands at the centre of his argument for a program of general semiotics:

> Semiotics is concerned with everything that can be *taken* as a sign. A sign is everything which can be taken as significantly substituting for something else. This something else does not necessarily have to exist or to actually be somewhere at the moment in which a sign stands in for it. Thus *semiotics is in principle the discipline studying everything which can be used in order to lie* (1976, p. 7, italics in original).

The process of transformation taking place in the clinic is a semiotic one. In the clinic, a child is represented on arrival in particular ways (that is, as a being understood by the parent as qualitatively different from all other beings). That representation is transformed into one inscribed as numbers and traces on a graph. As a semiotic phenomenon, the inscriptions are "*taken* as a sign" by nurses in the clinic; a sign of development. But this connection between numbers and development is socially constituted; a transformation of forms of representation. The transformation and the 'connections' it generates has

demonstrable effects on relations in the clinic and it is to these effects that the discussion now turns.

3.1 Quantified versions of the child's body

The transformation of the child's body can be examined as a series of 'moves' accomplished through the preliminary stages of the clinic visit. First the child is carried or guided in to the waiting room by the parent. The child is placed in front of the nurse who, using instruments (treated for the moment unproblematically) measures the child's body. The measurements stand as translations of the child's body; that is, what the parent might make visible as *qualitative* aspects of the child, for instance by giving an account of the activities the child "loves" to engage in, are translated into numbers. These numbers can be used to make quantitative assessments of the child. Crucially, the numbers, as traces of the child's development can be used to compare one child with another.

This shift from quality to quantity marks a significant alteration in the representation of the child. The sequencing of this altered representation is significant. The measurements are taken *before* the move to the private office for 'counselling'. The taking of measurements are a transformative ritual (Turner, 1967). The quantified representation of the child, that accomplished prior to the move into the private clinic room, was, in most circumstances, observed to play a significant part in developing and issuing instructions to parents.

It is this quantified representation of the child which nurses claim 'alerts' them or 'tells' them about how the child is developing. In the following example the nurse, Fran, 'explains' the measurements to a mother who claims to be unfamiliar with the notion of 'percentiles':

Fran: OK, length wise she's just slightly under the fiftieth percentile and she was at the twenty-fifth percentile last time so that's nice growth. Do you understand how the percentiles work?

Fran looks up from the chart as she is displaying it to Erica.

Erica: Kind of ...

Fran: It's basically if you had a hundred babies all the same age, she's right plump in the middle there'd be about fifty taller than her and fifty shorter than her /

Erica: / so she's in the middle then /

Fran: / so she's on the fiftieth percentile, um hm-m-m. If she were on the ninetieth percentile it would mean she's really tall for her age.

Erica: OK.

Fran: OK and weight wise she's just slightly over the seventy-fifth percentile, looks like it's about eightieth so /

Erica: / so she's gaining weight good now, right?

Fran: Um hm-m-m, she's gaining really well.

Erica: Oh, good.

Fran: That's nice.

Fran flips the pink graph over to reveal another, smaller graph on the other side of the paper.

Fran: A-a-a-and head circumference is just slightly under the seventy-fifth percentile, which is right around where it had been last time. What we're really concerned with is *seeing* the continual growth along the line? Like if say the weight's always been around the fiftieth to seventy-fifth percentiles and you come in and she's on the *tenth* percentile it ...

Erica: ... getting a little scarey! /

Fran: / alerts us that we should be watching her, seeing what's happening so that's (1.5) how that works.

Fran, a new graduate nurse, had worked at the clinic for less than one year. Unlike her fellow workers who all reviewed the graph measurements with parents before filling in the clinic assessment form, Fran was observed to either leave the graph until the end of the session or, as in this case, review it in the middle of the counselling session. This suggests a possibility that, for Fran, the graph does not yet hold the same meaning for her work as it does for her colleagues who have worked at the clinic for a much longer period of time.

Despite this, Fran 'announces' the graph as being useful in particular ways for workers at the clinic. Fran tells Erica that, with the graph, the nurse can 'locate' the child in relation to all other children. For instance, Fran indicates that "If she (Erica's baby) were on the ninetieth percentile it would mean she's really tall for her age". The same procedure is implied to hold for the weight measurement. Erica's assertion that her child can be said to be "gaining weight good now, right?" suggests that she has picked up the 'evaluative' nature of the graph. This is underlined by Fran when, a few turns later she points to the representative nature of the graph for clinic staff. She states that staff members are "concerned" with "*seeing* the continual growth". For staff at the clinic, the graph 'represents' a way of seeing, a perspective for seeing development in the child. That way of seeing is then drawn on as a resource by nurses as an "alert". If "alerted" by the graph, Fran suggests that further surveillance, further "watching" would be instituted so that staff members could "see what's happening". The surveillance function of the community nurse is imputed. Erica has been instructed in the uses of the representation of her child privileged by clinic workers.

3.2 Displacing alternate versions for representing children

Returning to a prior example of transforming representations of children brought to the clinic it will be recalled that two versions of Bridget's child, Ryan, were surfaced during the review of the graph [p. 202]. The historical version presented by Bridget constructed Ryan as a 'special' child, born prematurely, struggling to catch up to his contemporaries. The technical version, put forward by Jill, constructs Ryan as 'normal' and developing as expected. The nurse's account is located in the present. Its authority rests on her position as the interpreter of the measurements taken in the waiting room. The effect of the nurse's account is to displace the child's history in favour of the present, made visible through the technical act of measurement.

While Jill does not deny the history of premature birth, her use of technical resources permits her to invert the construction of the past as problematic into an unproblematic present. That is, Ryan's current, 'visible'

normalcy denies the *necessity* of making reference to his past. The inversion suggests that accomplishing transformations in representations of children has a significant effect on the nurse's work. Nurses include those aspects which favour the constructed version of the child while excluding aspects of other, alternative versions.

The potential for displacing particular representations of the child, primarily those steeped in the different and unique qualities with which a parent may construct his or her child are, I would argue, a result of the transformative ritual of measuring children. The potential for displacement is drawn on as a structural property of work in the clinic to construct asymmetrical relations between the nurse and the parent. Asymmetrical relations offer conditions upon which 'expertise' can be constructed.

3.3 Keeping parents enrolled

Central to any groups' attempts to persuade others regarding their distinct abilities as 'experts' is the establishment of boundaries around what can be pointed to as 'unique' or identifying practices (Melia, 1987; Schlotfeldt, 1988). According to Freidson (1970) such work might be described as professionalizing work where 'profession' is understood as

> an occupation which has assumed a dominant position in the division of labour, so that it gains control over the determination of the substance of its own work (p. xvii).

To what extent does this definition apply to the case of community health nursing as it is practiced at Hillcrest Clinic? The nurses made reference during interviews to their "mandate". This mandate involves responsibility for communicable disease control and the provision of community health services including maternal / child surveillance, well-child clinics, school screening and health education programs (Storch, 1985). However, as this work is primarily legislated, I would argue that these aspects do not, in fact, align with Freidson's formulation for professional work. Professionalizing work, that is, that aspect of work where members have "control over the determination of the substance of its own work" must instead be examined as *social* accomplishments, not legislative ones.

The work undertaken by nurses to transform the child's body in the clinic represents the social accomplishment of professional work in this setting. This transformation is not the result of a "natural correspondence" (Eco, 1976, p. 200). As I have argued elsewhere (Purkis, 1993), the position taken in this thesis stands against the version of expertise put forward by Benner, where the special abilities of a nurse endowed with an extensive amount of background experience is understood to practice 'more expertly' than others nurses with less experience. This is to attribute a natural correspondence between time and quality.

In the clinic, 'expertise' is a social accomplishment, represented in the ways in which parents and their representations of their children are displaced by representations asserted by nurses. The nurses' assertions constitute asymmetrical relations between nurse and parent. The 'artifice' of the correspondence underlying the asymmetrical relationship has, significantly, a 'visible' component. Nurses assert their expertise by enlisting parental support during the technical measurement process and then, 'show by saying what they see' during counselling.

The symmetry of the relationship can be altered by parents who question the nurse's instruction. However, it must be noted that challenges to the nurse's status as 'expert' were rarely observed during encounters in the clinic. The more typical portrayal of this aspect of the visit can be demonstrated with the following example. The measurements, converted by means of a chart, allow Helen to 'situate' the child within a certain "percentile" range:

Helen: OK she's sitting weight-wise between the seventy-fifth and ninetieth percentile.

Lynn: Uh hmm ...

Helen: Height-wise, pretty comparable.

Lynn: Uh hmm ...

Helen: So she's very proportionate.

Percentile measurements have the effect of neutralizing qualitative differences amongst children; the technical discourse employed in the measurement and subsequent documentation of the measurements is devoid of any individual

distinguishing reference. The professional encounter between mother, child and nurse establishes itself upon this neutral plane. Children who may be characterized by their parents as unique individuals are 'processed' as a part of the explicit service offered by the clinic nurses.

This is one of the most profound effects of the employment of the technical discourse: bringing unique, differentiated bodies into a space where they can be worked upon by the nurse based on a measurement which effectively neutralizes differences. As an effect of disciplined surveillance, the neutralization arises from the actions deployed by nurses and as such constitutes them as what Foucault has called "experts in normality" (1975/1977, p. 228).

The question which this analysis of conduct raises is why parents do not more frequently resist this 'neutralization' of their offspring? One reason might be proposed. Resistance is decreased because of a unique feature of the measurements: they are ambiguous, permitting a reading of the measurements which lead in opposing directions.

The neutralizing effects of the measurements enable nurses to offer advice to parents to alter the care of their child in order to make the child proportionate. While these generalizing functions of measurements are used primarily by nurses, at the same time, the measurements are read by parents as a particular and specific indicator of their child's particular development. Taking the measurement as one in a series, the parent is able to contextualize the particular measurement and attribute it specifically to his or her own child. The parent "enrols" (Callon & Latour, 1981; Latour, 1986, 1987) the nurse's technical representations. This has the effect of decreasing resistance to the nurse's instructions. As part of the enrolment process the parent now relies on the nurse's interpretation of the graph, through the 'expertise' implied through her association with the graph.

The process of enrolment is accompanied by particular types of associations amongst members and between members and the materiality of the life-world. According to Latour, enrolment always involves the displacement of goals (1987, p. 114). Typical conduct in the clinic underlines the influence of the

graph and how it was drawn on in encounters as being implicated in the displacement of alternative (i.e. parental) goals.

Broadening the scope of what is to be 'included' into the construction of experts, Latour's treatment of 'the technical' underlines the extent to which technical discourse is effectively strengthened as a consequence of translations cutting across representational spaces. For instance, consider the following sequence:

> Diane: This is, you've probably seen these, the growth on a graph?
>
> Sharyn: Yup.
>
> Diane: This is his weight here in grams and that's really nice, I mean it couldn't be better.
>
> Sharyn: That's good!
>
> Diane: He's in, the weight is really suiting the height nicely, you don't really need a graph to see it, do you? He's a nice shape when you see him in person.
>
> **Sharyn smiles and leans down to put her face closer to the baby's face.**
>
> Sharyn: Are you a nice shape?
>
> Diane: He's at the seventy-fifth in weight *and* height. It's really nice.
>
> Sharyn: OK, well he's always been that, right from the beginning.

In this example nurse Diane demonstrates a series of rapid shifts between domains for representing Sharyn's baby. The baby is four months old. This is his second trip to the clinic. Diane draws on this background assumption then when she suggests that Sharyn has "probably seen these" graphs previously. Sharyn's agreement has two effects. Not only is she acknowledging having "seen" the graph before but tacitly agrees that she will allow it to stand for her child's developmental 'progress'. Sharyn's goals are displaced and as a result, Sharyn is enrolled.

This is not to say that Sharyn is not interested in her child's weight and height. It is precisely this 'interest' which Latour takes as central to the process of enrolment. However, by displacing Sharyn's particular goals for her child, Diane

asserts the organizational meaning and it is upon this basis, that is, the organizational basis, that Sharyn's 'interest' is enrolled into the processes of work conducted in the clinic.

Diane points out the child's weight, first "in grams" and then, switching into a qualitative domain (based on the measurement, however), she claims that the weight is "really nice ... it couldn't be better". Diane follows this up by suggesting that the child's weight and height "suit" one another (thus he is 'proportionate'). Then she shifts domains again by claiming that "you don't really need a graph to see it, do you? He's a nice shape when you see him in person." Significantly, the claim that the graph is not needed to "see" how well the child is developing is made *based on* the graph; that is, the visual assessment of the child "in person" is supportive of but not prior to the technical assessment.

A parent may 'know' upon entering the clinic that their child is "healthy", the measurements taken by the nurse, interpreted during the encounter, can be taken away with the parent as a technical translation which 'confirms' their 'lay' knowledge. One mother who was asked immediately following the visit with the nurse about her impressions of the visit stated:

> Molly: Uhm, well of course, you know, how healthy the baby is. And like I sort of knew how healthy he was already. I always like to hear, like "Oh yeah, he's really healthy" and whatever.

Encounters between nurses and parents fabricate the child's developing body, in quite intricate ways, into the constitution of concepts such as 'health' in society.

Foucault (1975/1977) points to the numerous ways in which the child (and the parent) is "fabricated" into society through mechanisms of surveillance:

> Our society is one not of spectacle, but of surveillance ... the play of signs defines the anchorages of power; it is not that the beautiful totality of the individual is amputated, repressed, altered by our social order, it is rather that the individual is carefully fabricated in it ... (p. 217).

Measurements taken routinely, one might say, ritually, at every clinic session, draws the child's physical development onto a neutral plane. From this location the child can be regarded as one of many. At the same time, and for the purposes

of enrolling the parents, these measurements are recorded as individual traces of the child's own 'unique' growth pattern.

However, the shifting of domains of representation plays an important part in this process of fabrication. Rather than deflecting the centrality of the technical measurements of the child, translations which cut across representational spaces act to support and extend the technical. Latour describes this process of support and extension as the building of networks (1987). Networks are exemplified in the clinic by the discursive work engaged in by nurses to get these measurements across to parents. There is no 'natural' correspondence between a child represented as a numbered percentile and that of a "nice shape". The correspondence has been constructed in language. However, the *effect* of translation across technical domains, from 'exact' technical measures to more 'loose' visual perceptions, is to suggest that such comparison is not only possible but fundamental to the work conducted in the clinic.

I would argue it is precisely this type of encounter between mother and nurse which constitutes the unusual effect observed in the clinic where purposive work is conducted through, or accomplished by drawing on 'friendly', conversational techniques. Shifting away from the purposive technical discourse of 'percentiles' and 'grams', Diane moves to a more conversational mode when she states that the child is a "nice shape when you see him in person". The question arising is: why shift? As knowledgeable members operating in this setting the nurses' conduct suggests that work is facilitated in some way by this ability to shift between domains. Although perhaps impossible to 'prove' (if that were the intent) I might suggest, following Latour, that 'softening' the hard edges of technology serves to support the 'value' taken by members as inherent in the measuring devices, thus exponentially building on the already enrolled 'authority' of the nurse. Shifting between 'the technical' and 'the conversational' facilitates a continuing enrolment of the parent into the process of accomplishing the expertise of the nurse.

On the basis of individual traces recorded about the child's development, work is entailed for the nurse. The child is not 'lost' in the multitude of children, his "beautiful totality" (Foucault, 1975/1977, p. 217) is asserted by

recording his measurements and maintaining a record which, as nurse Helen informed mother Paula during the home visit, represents the child's "*permanent , legal* health record. This is what sits at the clinic ... is later, when he goes into grade one, it goes into the school system with him".

By means of the technologies of measurement, the child's body is "fabricated" into the social order of society. This fabrication represents a tightly interlaced representation of the child consisting of the professional version produced by the nurse relying on her technical expertise (audit and measurement technologies), in conjunction with the parent's personal knowledge about the child (by responding on the call to account). A version which, while in 'play' during interactions between nurses and parents, feeds into the powerful effects which inject meaning and direction into the interaction.

3.4 Constructing expertise

Two functions for marking the clinic's boundaries have been identified. One was the constitution of the clinic as a location where competing messages about child rearing could be compared with the 'best' message, that is, the message available from the community nurse. The second, suggested by the foregoing discussion and explored in further detail below, was the constitution of the nurse's message as an 'expert' message. 'Expert' messages, I will now argue, rely on using technical discourses to construct the child's body as 'the same'. This argument articulates with the previous discussion where it was pointed out that nurses translate the child's qualitative representations into quantitative representations. The representation is obtained by measuring the child's body and inscribing these measurements onto the graph, now as 'traces' of that former, qualitatively unique child. The 'results' as expert pronouncements upon the progress of the child, delivered during the course of a counselling session are legitimated through the use of technical discourse by nurses who have 'enrolled' the parent into this translating process and serve to legitimate future conduct based on the representation.

The process can best be illustrated by examining an instance where the nurse appears to separate the technical discourse from her own performance as a

skilled observer. Such a shift is demonstrated in the following encounter between nurse Diane and mother Molly:

Diane: ... if you look at the graph of course ... and uhm, when you look at his body he's a nice shape, and his head size is at the seven... at the fiftieth percentile,

Diane shows Molly the growth on the chart using her pen as a pointer.

Diane: ... so a really nice increase in, it's either a nice growth here or maybe there was a *slight* mis-measurement last time /

Molly: / Uh, actually /

Diane: / it is possible /

Molly: / his head *has* grown /

Diane: / have you noticed the growth?

Molly: Oh, yeah. Yeah, absolutely, 'cause I always thought he was, he looked so ... ti-i-iny , so really, really petite but I have noticed his head, in fact his hats I can't, he won't fit into any of his hats any more **(laughs)**

Diane: That's ni... that's good. He's taken a twenty-five percentile jump. And it kind of follows along *more* with his birth circumference ... it's nice, it's really nice.

Molly: Good!

Diane: Let me just feel his fontanel area here ...

Diane leans forward and places her hands on the baby's head. She feels gently around the top of his head then leans back in her chair again.

Diane: ... that's good. It's nice and uh ... it's a good rate of growth probably, uh-h, because if you just feel the fontanel, this open area?

Diane leans forward again and shows Molly where to place her hands so she can feel the fontanel.

Molly: Uh hm-m-m ...

Diane: It's nice and open still? /

Molly / oh yeah ...

Diane: It's not closed or it's, it's not *bulging*. You get concerned if there was a bulge there but it's not, it's a nice shape there. A nice healthy head growth.

In this example, as in the one reviewed previously between Diane and Sharyn, the nurse uses the graph to support her own observations of the child's body. She suggests that "when you look at his body he's a nice shape". The child's visible shape is connected with the measurements. The professional judgement of a "nice shape" is supported by and supports the technical measurements.

The importance of corroborating one type of measure with another is demonstrated as the interaction proceeds. When Diane 'discovers' that the baby's head circumference has increased at a rate exceeding expectations, she suggests that this indicates "either a nice growth here or maybe there was a *slight* mis-measurement last time". By 'investigating' further with the supportive performance of a tactile examination of the baby's head, pointing out anatomical features of her examination (further reliance on 'the technical'), Diane corroborates her diagnosis of "nice, healthy growth" by playing the 'facts' off one another.

Diane has three 'facts' before her: first, an 'aberrant' reading displayed as a dip at the last visit which has been made up at this visit; secondly, Molly's observation that the baby's head has grown based on the fact that "he won't fit into any of his hats any more", and thirdly, her own tactile examination of the baby's "fontanel area". The matter is 'settled' through combining the technical discourse about percentiles with the performance of an examination of the child's head. Demonstrating the extent of her 'enrolment' into this process, Molly 'saves' the graph when, using her own forms of representation, that is, hat size. Molly supports the claim that the child's head has grown. The advantage of having the parent 'enrolled' is that Diane can 'risk' admitting that another member of staff may have made a "*slight* mis-measurement last time" without apparently suffering any loss of face as an individual member representing the clinic as a location of expertise, that is, where a better message on child-rearing can be obtained.

4.0 Making development predictable

The space within which this 'better message' rests relies on the nurse's ability, through the processes described above, of making development visible in

particular ways so that it is rendered *predictable*. Having constructed the conditions for prediction, the nurse is then positioned to address the parent as an expert.

The effect achieved of transforming individual children, unique in their parents eyes, onto a table where all these differences are displaced in favour of an assessment which compares all children of the same age with one another facilitates a particular mode of practice in the clinic.

Measuring the child acts symbolically to mark the entrance to the clinic. As an institution identified with specific functions, that is, immunization clinics and the assessment of child development, the act of measuring reinforces the notion that those seeking the services of the clinic must make accommodation, or undergo some form of transformation to be taken into this institution. Differences pertaining outside the clinic are displaced in favour of specific representations obtained by being processed inside the clinic. Measurement, as it is constituted in the clinic, is a structure which serves to constrain understandings of the child but this very constraint acts to enable a particular image of work operating in the clinic: the 'gaze' constitutes the child in particular, productive ways for the nurse.

Achieving the position of expert relies to a very great extent on the nurse's ability to predict what might happen next. The nurse's position relative to the client is affected by her ability to maintain the primacy of the measurement. It was demonstrated that one laugh could make a considerable impact on the symmetry of relations between the nurse and parent. Such lack of credulity towards the nurse's measurements was rare, however. As a result, with black boxes relatively speaking, well sealed, the nurse quickly achieves asymmetry in her relations with parents and assumes a position of dominance within the encounter.

It is this dominant position which both furnishes the 'gaze' and serves as its backdrop. The relation between nurse and parent is a very particular one. It is marked symbolically with the taking of measurements to 'announce' entrance into the clinic. It is significant that measurements are located as an aspect of work to be conducted in the clinic itself. That is, parents are not asked for the

weight of their child nor for their child's height. Instead, it is a function of the clinic to construct these measures -- but for what purpose? While demonstrated in this chapter to be frail, based as they are on assumptions examined only rarely, the measurements are drawn on by nurses to transform the child's body and in so doing, construct a particular relation toward the client. The child's body is the focus of the transformation. The parent's position as physical assistant in the waiting area implicates them in the production of the transformation -- but they remain outside of it as an assistant to technical aspects of the professional nurse's work. Once in the counselling room however, parents demonstrate remarkable acts of 'translation', for instance, 'saving' graphs in representational danger due to "*slight* mis-measurements". Action in the clinic is clearly influenced by powerful relationships.

As Foucault notes, relations such as those illustrated are only made possible by the conditions framing and informing the measurements as they are revealed. In order to explore the relationship between the nurse and client further, including the conditions supporting that relationship, the discussion turns in the next chapter to an examination of how the particular 'gaze' constituting the child as 'the same' is brought to bear on the practice relationship.

CHAPTER EIGHT

Surveillance in the Clinic:

disciplined and disciplining conduct

> Our treasure is where the bee-hives of our knowledge are. We are ever on the road thither ... we care at bottom but for this--to "bring something home". As regards life otherwise, so-called "experience",--who among us has even earnestness enough for it? Or time enough? On such matters, I fear, we were never really "by the matter"; for our heart is not there--and not even our ear!
>
> F. Nietzsche, The Genealogy of Morals, (p. 1)

1.0 Introduction

The concern in the previous chapter was to explore the influence of the ritual act of measuring children brought to the clinic by parents for immunization. The visit to the clinic is quite clearly evaluative in nature. Giving immunization at the completion of the counselling session would appear to mitigate these evaluative aspects of the visit. Nevertheless, the significant point to bring forward from the preceding chapter is not that measuring the child should be seen as providing pure 'facts' upon which the nurse evaluates all that is told to her by the parent during the counselling session. This rationalist framing of such an account of practice represents, in part, the nurses' interest in measuring work. The reading I would like to put forward goes much beyond this account. The analysis undertaken in the previous chapter will now be turned towards a discussion which situates that transformational aspect of the visit as significant within the wider effects of conduct undertaken as 'counselling' in the immunization clinic.

I will argue in this chapter that the act of measuring the child, and the representational space into which the child (and parent and nurse) are subsequently located as a result of that measurement, provide conditions for undertaking community nursing by modes not previously recognized within the nursing literature. Perhaps the study which comes closest to the perspective to be put forward in this chapter is Bloor and McIntosh's (1990) study of British health visitors. An important aspect of their study is that they have given clients a voice. Bloor and McIntosh, however, merely point to the 'heavy' hand of surveillance. The reader is introduced to the extent to which parents are aware of surveillance enacted by health visitors. Already there is an indication of 'difference' in the enactment of community nursing in the present study. It will be recalled that, in the present study, parents construct the clinic visit as 'friendly' and that nurses treat it as 'non-work'. The possibility arises that because of the extent to which work undertaken in the clinic is apparently favoured over work undertaken in the client's home, a radical 'shift' has occurred in the understanding of community nursing work. The possibility that such a 'shift' may have occurred has not previously been addressed in the literature on community nursing work.

In this chapter I intend to explore the wider effects of work undertaken by community health nurses. The process of measuring young children attending the clinic has been described as an act in which parents are enrolled, first as assistants to the nurse and then, into versions of their own child constituted within representational spaces relying on a technical discourse. The point raised at the end of the previous chapter was that measurements neutralize differences amongst children making prediction possible. Prediction is a "facility" (Giddens, 1984, p. 88) constituted by the nurse as a result of acting on the child in particular ways. It contributes to the construction of the nurse as an 'expert' in child development.

But this version of expertise is only one form enacted in the clinic. Another form of 'expertise', one which runs more systematically than that demonstrated in the transformation of the child's body from qualitative individual to a quantified 'same', will be advanced in this chapter. Investigating

the nature of surveillance engaged in at this clinic, conduct will be examined in terms of the wider social context in which these practices are set, that is, the period which has been called "late modernity" (Giddens, 1991).

Investigating conditions which establish expertise and permit it to function, work conducted in the clinic is placed in this chapter within the context of a society widely recognized in social theory as 'disciplined' but crucially, at the same time 'disciplining'. The implications of the recursive nature of representations made of children are of concern. Whereas previous chapters alluded to the nurse as exerting a powerful influence during the counselling session, the aim is to contextualize that influence, not in order to mitigate it but rather to underline the extent to which conduct in the clinic picks up and extends wider disciplinary functions already operating within society at large.

2.0 A 'discipline' of health promotion

Fernandez uses the term "inchoate" (1986, p. 235) to represent the sense of an entity which is reached for through expression and action but never quite grasped in the struggle to understand 'who we are'. At Hillcrest Clinic, 'health promotion', as an aspect of the worker's identity, represents just such an 'inchoate' object. Health promotion gives nurses an identity; it marks them as different from other nurses who, so it is claimed, are primarily concerned with caring for the ill or diseased. For instance, Kay drew out this distinction as she reflected on different work positions she had held prior to coming to Hillcrest Clinic:

> Kay: This is quite, quite different. The only similarity really is that you're going into people's homes. Well, with VON nursing and home care nursing you were doing a fair amount of teaching as well, but this, public health type nursing is uhm, ... I can hardly even compare the two! **(laughs)** Especially when I think what I did originally. And yet ... having progressed this far with it and learned new ideas, new theories about what we're doing and the types of nursing theories that we should all become familiar with! **(laughs)** to see how it applies, not just to an individual but to a community and that's what's making it kind of interesting right now is thinking of the client as a community, be it a school community or a community of a district or a community of **(sighs)** a cultural group or something like that so it's sort of taking nursing theory and applying it to a much broader

> perspective than just one single individual or the single individual's family. It's interesting to see how the different systems fit together and overlap?

Kay began her nursing career as an intensive care nurse. Although she reported having "good feelings about the work" she was doing in hospital, that she "found it very rewarding", the shift work and "all those political reasons" account for her turn to community health nursing. Before coming to work at the clinic where the study was conducted, she worked for two years with the Victorian Order of Nurses (VON) doing home nursing. She describes "enjoying the hands-on nursing care aspect of that job".

In the description of her present work environment Kay suggests that the community health work is "quite, quite different". The "only similarity" with the VON work is that the work takes place in "people's homes"; then, there is consideration given to the teaching which she suggests went on as part of her VON nursing. Even with these similarities however, Kay insists that she can "hardly even compare the two!" These "inchoate" aspects of her identity as a community health nurse are apparent when Kay attempts to give expression to what is typically engaged in as a practical act. Her verbal account of work demonstrates

> the underlying and overlying sense of entity which we reach for to express (by predication) and act out (by performance) but can never grasp (Fernandez, 1986, p. 235).

She laughs at her attempts to try to compare her present work with previous work situations as though the differences between them are so vast the comparison is absurd. Her sigh points to a sense of frustration in expressing her 'self' as a community health nurse. Her question at the end of the transcript segment seeks confirmation that her account will 'count' as a rendering of the 'difference' between community health nursing and other forms of nursing.

2.1 Understandings embedded in practice: Garfinkel's thesis

Despite the difficulty in providing a discursive account of the work conducted by community health nurses, in practice, this form of nursing is accomplished smoothly and efficiently. Nurses do not appear to struggle over

the 'doing' of their work. Encounters with individuals attending the community health clinic, Senior's Drop-In clinics or during home visits were entered into quickly, proceeded smoothly and, in most case, ended with what appeared to be mutual agreement regarding what was accomplished during the visit. The practical accomplishment of work stands in contrast, then, with Kay's struggle to describe it.

I would argue that discrepancies between accounts and actions point to a possibility that accounts of health promotion are presently being worked out by community health nurses. In line with Garfinkel's thesis, the discussion which follows starts from the premise that what passes as community health nursing work is taken-for-granted and that it is only because nurses have been called to account by the researcher that such descriptions are made difficult. It can be expected that it is at those moments when practice is questioned, whether by a researcher or by a member of the community to whom they provide a service, that 'reasons' will be given.

The error which writers who seek to constitute health promotion as a new practice domain for nurses have made is to assume that change will occur when 'new practices' have been developed (Pender 1987; AARN, 1987; Dodge & Oakley, 1989; Chalmers & Kristajanson, 1989; Higgins, 1989; Anderson & Tomlinson, 1992; Kelly, 1992b, 1992c; Burnard, 1992). This position on theory as a top-down phenomena is rejected in this thesis as it ignores factors influencing the constitution of social conduct.

The problem may partly result from the 'abstract' nature of 'health' as a concept to be implemented into practice. For instance, hospital nurses can account for their work in terms of amounts of drainage from surgical wounds, observations of incision sites, amount of analgesics given each day and so on. The hospital, as a location for practice, presents its own epistemological problems. But consider 'health' and the promotion of health. How is it possible to account for having 'promoted' such an abstract entity? Unlike redness around an incision which can be pointed to as 'normal healing' or 'infection', what 'signs' of health will community health nurses 'look' for?

Despite the abstract nature of 'health', nurses engage in work they call health promotion unproblematically. It is within this practical accomplishment of work that, following Garfinkel, I am arguing that a 'discourse of health promotion' arises.

Nurses at Hillcrest Clinic already have existing methods to account for their practice. As Kay's account demonstrates, there are "nursing theories" to be applied, 'plans' to be completed as part of the fulfilment of 'duties' of a community health nurse. There are routines for conducting home and clinic visits. Present understandings and enactments of practice are deeply interpenetrated by understandings derived from the recursive constitution of practice, such as ritual representations of children's 'development' and the accessibility of 'competing messages', which draws on such structures available in these accounts of practice.

These understandings are not static. If Garfinkel is right, the understandings will shift and move, during interactions, during the accounting for practice which goes on as a part of the visit itself. While one concern of this chapter is to draw out those understandings of practice constructed for public consumption, framed and apparently solidified because of existing power structures constituting 'work' in the clinic, more importantly, I will aim at drawing out the shifts occurring *within* interactions. By pointing to the effects which action in the clinic has both on nurses and clients, the aim is to excavate those understandings which may not be produce-able as discursive accounts of practice but which are observable as the practical accomplishment of work.

2.2 Setting aside 'the visible'

In the following example, the enactment of community nursing practice will be explored. These practical accomplishments of work stand in some contrast to Kay's discursive account discussed above.

The work of obtaining measurements of the child at the clinic offers an opportunity for nurses to visually survey children brought into the clinic. This visual surveillance would not appear to have as its primary aim that of observing the child for signs of illness or physical abuse. 'Statutory' types of

surveillance pervade accounts such at that given by Bloor and McIntosh (1990). Such enactments of practice were not upheld in the present study. This can be demonstrated with reference to some organizational changes which occurred during the field work.

Early in the observation period, parents of children up to the age of six months were requested to remove all the child's clothing prior to placing the child on the weigh-scales. At this point the child's body was *available* to staff members to examine. On one occasion this availability of the child's body was taken up by Noreen, the community health nursing assistant (CHNA). The observation notes pertaining to this incident are reproduced below:

> Having completed the measurements, Noreen took a hold of the child's legs and rotated her hips telling Glena that this was to "check for any clicks". Noreen rotated the hips a couple of times and then told Glena that she was unsure whether or not she had felt something. She asked Glena to leave the child undressed until the nurse could come to check. At Noreen's request, Fran came out of the first clinic room and performed the same hip rotation procedure on the child. She told Glena that she didn't feel any clicks but showed Glena what she described as "an extra skin fold here" on the posterior aspect of the child's right leg. This was explained as sometimes being associated with hip problems in children but that because she did not feel a click in the child's hip with rotation, she felt it was just the way the tissues were arranged which produced this skin fold. Fran asked Glena if she'd had the baby in for the six-month check-up. Glena stated she had and that the doctor had checked the child's hips and had not found anything problematic. During this examination the child began to have a bowel movement. This movement was noted by both Glena and Fran as being "solid" and "very formed". Fran then told Glena that she could dress the child again, leaving the left leg free of clothing.

Two aspects of this encounter are important to note. First, the relays through which information is passed. Noreen's action of rotating the child's hips to "check for any clicks" is undertaken as a 'matter of fact'. Permission is not sought although an account for the action is given. The result of the test is inconclusive and a nurse is called in to double check. This implies that, as a "nurse", Fran is better qualified to make an assessment of the hips. Although not finding any palpable evidence of problems with the child's hips, Fran points to a

'visible' sign that there may be a problem--the "extra skin fold". Noreen's initial suspicions are supported by the more highly qualified nurse. 'Team work' is instantiated while at the same time hierarchical structures at the clinic are displayed and reproduced. As a consumer of this service, Glena is instructed in the organization of practice pre-existing her entrance to the clinic.

The second aspect of note is the 'extension' of these hierarchical orders into the wider health care system. Fran invokes an expectation that Glena will have taken the child somewhere for a 'routine' "six-month check-up". Displaying her own knowledge and, significantly, giving an indication of her own discipline as a mother, Glena indicates that the child has been 'checked' by a doctor and that no problems were found. This 'rehearsal' of hierarchical structures in the health care system is interrupted by the child's bowel movement. The matter of 'hip problems' is promptly closed and Fran announces that the work of the clinic should proceed.

Surveillance at the clinic then, represents only one aspect of a much wider concern with observing the 'development' of children within this particular society. These networked locations for surveillance are introduced in taken-for-granted ways, treated as expectations or norms of behaviour.

Part way through the observation period a re-allocation of staff members took place. Previously, Noreen, the nursing assistant, undertook the weighing, measuring and recording of results for all but the Thursday morning clinic. Half-way through the field work, Noreen was allocated to work on school records on a full-time basis. This re-allocation had taken place in two phases. The year preceding the field work, Noreen's services were withdrawn from the Thursday morning immunization clinic session. Nurse Helen had incorporated these events into her account of work:

> Helen: These time slots are all slotted twenty minutes and half the time you're *starting* behind. Because you've got to remember Thursdays now are a sort of unique circumstances that we weigh and measure our own babes, whereas any other day of the week we've got the CHNA out there so they are all slotted and weighed so it kinda keeps you on track a little quicker. So they sort of chose our day in that we were faster interviewer people.
>
> MEP: And is that just in the morning?

Helen: Yup, just Thursday morning. Just to free up the clerical time.

This account demonstrates how understandings are drawn on to produce accounts of work. Helen points to the organizational function served by the nursing assistant ("any other day of the week we've got the CHNA out there so they are all slotted and weighed so it kinda keeps you on track a little quicker"). Helen suggests that the weighing and measuring of children is understood as an 'additional' task which, as "faster interviewer people", the nurses at the Thursday morning clinic had been requested to do. For the nurses the opportunity to see the child's unclothed body is not framed as an aspect of their work of surveillance as much as it is a necessary pre-requisite for the work conducted in the private clinic room.

Commenting on the second phase of the re-allocation, nurse Diane pointed to the way in which 'troubles' with the change had been framed by clinic staff members:

Diane: That's exactly what happened with taking [Noreen], the person at the scale away. And she would do all the converting and the paper work and the filling in of different forms and my God! ... All the different intricacies of paperwork and we, last year we decided that on Thursday mornings that the three of us wouldn't mind trying without her, we would do this weighing because she was needed on the schools and uhm ... this year, there's nobody doing it anywhere and it's just ...

MEP: Sort of like if you survived, everybody else can survive ...

Diane: That's right. that's what people are saying around here. "You guys said it was OK and blah, blah, blah ... " Ohhhh! I don't think there's any hard feeling amongst ... we get along really well, I think here.

Again in this excerpt, trouble is framed as 'extra work' for staff members. Diane suggests that their willingness to "try" doing without Noreen at the Thursday morning clinic was treated by clinic managers as a precedent. Now all members of staff were being asked to undertake this 'extra work'. Similar to Helen's description of this event, there is an indication that the time spent out in the waiting area weighing and measuring children is understood by staff members as

reducing the time available to be spent in the private clinic office. Such references demonstrate a preference on the part of staff members for work taking place in the office.

In response to the perception that, with Noreen's permanent re-allocation, staff had 'less' time for counselling, the 'decision' was reached at a staff meeting that parents would be requested to remove their children's clothing only for the first visit to the clinic. At that visit, the child would be weighed and measured with no clothes on. At all subsequent visits, the child was to be weighed fully clothed (although coats, hats and mittens were observed to be removed). 'Saving' the time spent for a parent to undress and then dress the child again is demonstrated in this 'decision' to be privileged over the opportunity to visually survey the child's unclothed body.

The organizational 'problem' brings interesting preferences to the surface. Clearly the nurses privilege the time spent in the private clinic office. By that point in the encounter they have transformed the child's body as qualitatively different into a body which has been quantified and is now can be regarded as predictably 'same'. This particular representation of the child is the basis upon which work in the counselling session takes place. However, the representation necessarily places limitations on the counselling session *from the outset*. The overall effect of these decisions and the resulting performance of work is to "institutionalize" (Lyotard, 1979/1984) a particular image of work. This matter is now taken up with reference to Lyotard's work on the "language game".

2.3 Institutionalized forms of surveillance

Interactions engaged in by language partners in the clinic setting are influenced by hierarchical structures operating in society in the broader sense. The nurse as a health care professional is recognized by her employers and those to whom she provides her services as being in a position to carry out her job advertised in the present case as the promotion of health. This discursive account of work practices is complemented by physical actions associated with the practice of nursing. Together an image of work is facilitated which is that of an enactment of expert, skilled practice.

Morse's study (1991a) examining the nature of nurse-patient relations recognizes the influence of structures such as hierarchy within organized settings such as a hospital. However, Morse treats these relations as though they were a barrier to 'good' practice. Morse treats hierarchical structures as something which clouds the lens through which nurses 'see' clients. Such a perspective on structure is, I would argue, what Lyotard describes as

> too "unwieldy": its point of departure is an overly "reifying" view of what is institutionalized (Lyotard, 1984, p. 17).

As I have argued in chapter four [p. 103], it is overly simplistic to imagine that powerful structures enabling the nurse to approach the work setting to do work, the same structures which also constrain the version of work as it is practiced, could be easily removed and replaced with structures which redress the power imbalance.

The view taken in this thesis is that, rather than clouding the lens through which the nurse 'sees' the client, structural properties such as hierarchy and modes of representation serve to *focus* the lens through which clients are 'seen' and thus, 'known'. Rather than occluding what can be 'known' about clients, these properties make knowing possible.

In the preceding chapters, examples of interactions recorded between nurses and clients have been used to demonstrate that a perspective such as that taken by Morse excludes the very matter upon and within which interactions are constituted: that is, 'the social'. To underline this point again: it is only by drawing on structures such as those of hierarchy and modes of representation that relationships between nurses and clients in organized settings, whether hospitals or 'friendly' clinics, are constituted. The constitution of such 'relationships' is first and foremost a social accomplishment.

In the above analysis I have suggested that nurses at Hillcrest Clinic have demonstrated a preference for work taking place in the private clinic office over that 'available' to them as visual surveillance in the public waiting room. It is in the private clinic office, when representations of children's bodies are 'settled', representations which frame institutions for talk in the clinic, that the pervasiveness of talk comes again to the fore.

3.0 Rehearsing 'good' parenting

In this section the analysis of research materials will turn to examine the organization of this talk in the clinic. Materials from the life-world of the clinic clearly influence the organization of work. For instance, previously Kay referred to "nursing theories" in an account of her work as a community health nurse. In chapter six it was pointed out that, in the absence of 'concerns' forthcoming from parents in the counselling session, nurses could use the assessment form (Appendix D) to facilitate the production of accounts of parenting [p. 161].

The growth charts, the record of weight, height and head circumference taken six times over the child's first two years, stand as further instances of such materials giving form to the nurse's work. Nurses claimed that the charts "alerted" them to potential growth problems. Fran describes this to mother Erica in the following excerpt from their encounter:

> Fran: What we're really concerned with is *seeing* the continual growth along the line? Like if /
>
> Erica: / uh huh /
>
> Fran: / say the weight's always been around the fiftieth to seventy-fifth percentiles and you come in and she's on the *tenth* percentile it ... /
>
> Erica: / getting a little scarey! /
>
> Fran: / alerts us that we should be watching her, seeing what's happening so that's (1.5) how that works.

Fran suggests that increased surveillance "should" be applied in order that the staff of the clinic can "see what's happening". The visual metaphor, commonly associated with the act of surveillance, is prevalent in this account. Fran's account of work suggests that it proceeds 'rationally' beginning with the discovery of a visual sign of developmental problems, visible on the growth chart, through to assessment ("see what's happening") with the implication that once 'seen' the problem can be rectified.

In practice however, this 'rationalist' model of practice was not observed. On the one occasion when an example of just such an "alert" was made visible

through the mediation of a growth chart, the visual metaphor 'dropped out' in favour of a 'verbal' mode of practice. This example will be explored in greater detail in chapter nine. For now I want to explore further the extent to which the graph was networked with other work practices, not limited in the way Fran's account of it would suggest. Although clearly influencing questions asked of parents, the graph, on its own, is not treated as sufficient for work. Visual mechanisms for surveillance are interlaced with other forms of surveillance. In the following sections an explication of how surveillance is enacted in the clinic will be undertaken.

3.1 Locating a 'site' for surveillance

In chapter six, drawing on Giddens' notion of 'regionalization' it was suggested that localized differences in conduct observed between private and public spaces could be explained where clinic members, endowed with social knowledgeability, were understood to 'read' the signs in the clinic. Once in the regionalized spaces of the clinic, signs were read to inform clients 'when to talk' and to some extent 'what to talk'. Combined with this underlying knowledgeability, parents receive prompts from nurses who draw on structural aspects of the life-world of the clinic to provide further 'cues' informing members regarding the work to be conducted in the clinic. These 'cues' should be understood not only as informing parents but also providing confirming 'evidence' for nurses as they reproduce existing, understandings of work in the day-to-day operations of the clinic. Messages received and demonstrated through members' conduct in the clinic is that parents, as clients of the 'service' offered at the clinic, are 'positioned' in such a way that they 'experience' obligation to give accounts to the nurse.

The claim has also been advanced in the preceding section that nurses in this clinic have largely set aside direct surveillance of the child's body in favour of a more 'indirect' mode of practicing; that of 'auditing' accounts of parenting. These aspects of work in the clinic represent 'conditions' facilitating the conduct of community health nursing in this particular field of practice. To extend this, these 'conditions' can be examined as constitutional of the 'site' for practice.

The movement of nurse, parent and child to the clinic office, the regionalized space for conducting 'counselling', points to the preferred site of surveillance: parental accounts. 'Site' is used in the sense derived from Foucault:

> In this hinge between two things a resemblance appears. A resemblance that becomes double as soon as one attempts to unravel it: a resemblance of the place, the site upon which nature has placed the two things, and thus a similitude of properties; for in this natural container ... adjacency is not an exterior relation between things, but the sign of a relationship, obscure though it may be ... (Foucault, 1966/1970, p. 18).

The site for work at the clinic, I would argue, is the parental 'account'. The conditions facilitating the construction of the particular form of relationship described above is to impute to these relationships (i.e., nurse -parent; nurse-child; parent-child) a sense of "adjacency". The adjacency is not an exterior relation, that is, there is no relation other than that constructed within these particular societal structures. Rather, the move to the clinic office and the ceremony of calling the parent to account serves to instantiate those structures conditioning the relationship as well as reproducing in this particular instance, all those structures which until that moment are without expression (see Giddens, 1984 on structures).

Foucault invests the locating of action at a 'site' with these productive capabilities; that of investing structures lacking agency into instantiated expressions of those structures:

> From this contact, by exchange, there arise new resemblances; a common regimen becomes necessary; upon the similitude that was the hidden reason for their propinquity is superimposed a resemblance that is the visible effect of that proximity (Foucault, 1966/1970, p. 18).

The nature of the relation as a social construction suggests that in theory, any number of "new resemblances" might arise from this contact between signs. Thus a "common regimen becomes necessary", a regimen which 'orders' the relations and, in so doing, makes "visible" the effect of the contact and exchange arising from the relation.

Accounts given by parents in the clinic can only ever provide resemblances of reality--such is the nature of accounts (see Garfinkel, 1967 and Raffel, 1979). Of interest at this point in the analysis is how such resemblances are organized through the day-to-day work regimens drawn into the relationship, that is, 'expressed', which give the *appearance* of security. The analysis proceeds to examine conditions within which nurse-parent encounters produce resemblances of parenting which are verbal expressions of understandings regarding parenting. The position informing this investigation is that accounts of childhood development as the 'site' for work, should be understood as having been constructed and only possible within institutional constraints pertaining to the clinic. That is, only because of the institutional constraints enabling accounts to be produced are nurses then in a position to claim to 'see' development by auditing accounts.

3.2 Disciplined constitution of "change"

The following example is offered as a way in to the excavation of labour engaged in by nurses to 'do' work in the clinic. The example is given in two sections. In the first section, the nurse, Fran, demonstrates the means of making an assessment of 'change'. In the private clinic room, such an 'assessment' informs and supports, that is, it is networked (Latour, 1987) with the measurements taken of the child's body out in the waiting room. In addition to the concrete measures obtained by using weigh-scales and tape measures, Fran seeks verbal renderings of the child's physical abilities from the parent. Erica, mother of four month old Loraine, provides an account of Loraine's "developmental" change since the last visit.

Fran: OK, and what sort of things do you notice her doing now, developmentally? that she wasn't ... see when you were in here at two months?

Fran looks briefly at the nursing record on the desk in front of her then back at Erica.

Erica: Uh-h-h, she's talking a lot ... she's quite vocal *sometimes* ... she's not too vocal today **(laughs)**. Uh-h-h she seems to be grabbing things a little bit. She learned how to pinch real good! She's pinched me ... and uh, (2.0) I've

given her some toys to play with and she's really fascinated by those.

Fran: Is she pick... is it the toys that she's picking up or more that she's watching?

Erica: Uh-h-h-hm, she's got a uhm, a thingamajiggy ...

Erica points at the ceiling.

Erica: ... a mobile! And uh, she really likes that and I've given her a mirror to look in, so the play school thing has a mobile on it, she loves that. She rolls it and she looks at herself and talks and ... **(laughs)**

Fran: OK. Is she rolling yet?

Erica: She's trying to, she's *really* trying to *turn* her back and her hips but she can't quite get the leverage to push herself over.

Fran: OK. Well, she probably will surprise you /

Erica: / she rolled over actually.

Fran: Oh, really!

Erica: A month ago, like from a ... from front to back but she doesn't know how to do it back to front.

Fran: OK.

Erica: But she only did it once for me, she hasn't done it since so, I think she maybe had a little spurt of energy that day or something! **(laughs)**

Fran provides Erica with a clear instruction at the outset of this exchange. She seeks an account from Erica of what Loraine is doing now, "developmentally", that she was not doing previously. The parental account of physical growth patterns sought by Fran is framed in a question resonant with the colonization of the child's body by medical and psychological discourses. Inherent in the instruction given by Fran is not only that the baby, Loraine, will have developed, but that Erica as her mother, should have noticed this development, marked it, recorded it and be able to reproduce it verbally in this setting. The "new resemblance" (Foucault 1966/1970, p. 18) drawn into the discourse of giving accounts at the clinic is instantiated: a primary function of parenting is to monitor children's 'development' *in particular ways*.

Responding to Fran's question, Erica provides information on several of Loraine's 'abilities'. She mentions Loraine's verbal abilities, her fine motor skills, and, with some prompting from the nurse, her gross motor skills. Fran's initial request represents a 'disciplined instruction'. That is, drawing on background assumptions about the nature of 'development' and 'parenting', Fran asks a question which swiftly positions herself, Erica as receiver of that particular message and Loraine as the referent of the message. Fran 'disciplines' Erica by positioning her so that now Erica turns as sender of a message constrained within a 'developmental' discourse. Constrained by institutional boundaries, this response defers other, alternative discourses. Erica is being disciplined against talk of objects (toys and mobiles) and her daughter's response to these (fascinations, things she "loves") towards talk of visible action (rolling and picking toys up). The 'discipline' provides a signal for Erica regarding 'what to talk'.

The 'successful' accomplishment of a response to Fran's request relies then, on Erica's ability to lock into and generate an account resonant with a particular discursive form. As this particular example shows, Erica is 'assisted' in her production of such an account by Fran's occasional guiding prompts: "is it the toys that she's picking up or more that she's watching?" and "Is she rolling yet?" Fran's guidance 'disciplines' Erica: she informs Erica in these ways, with these prompts, what sorts of 'developmental' change she wants an account of. Erica's abilities to draw on the developmental discourse are, through this disciplining action by Fran, guided, shaped and formed, adding texture to Erica's developing discursive abilities.

Erica demonstrates an ability to report on several topics organized around the larger category of childhood development. Fran's verbal prompt, seeking particular information on the baby's ability to roll, extends Erica's demonstrated knowledge of topics included under the category of development. Fran's prompt 'instructs' Erica by refining the category of development even further than Erica has already demonstrated it.

Childhood development, and Loraine as a physical example of this process, are constructed within this meshing of parental demonstrations of

accounts which are, significantly, already disciplined. That is, Erica 'already knows' that her account must be organized around an assessment of her child's movements, her verbal skills, her fine-motor skills. Discipline, the effect of intricate forms of surveillance, characteristic of the late modern age (Foucault, 1963/1973, 1975/1977; Giddens, 1984, 1990, 1991; Bauman, 1992a, 1992b) has already influenced the ways in which she 'sees' her child.

The accounts are guided or prompted by input from a member of the 'expert' group of professionals. The nurses at the clinic have created a space in this particular societal arrangement enabling nurses to further define what development consists of. Disciplining understandings of what childhood development 'normally' consists of are 'shared' with parents through the mechanism of disciplined instruction. Aspects of what nurses take to properly come under the category of 'development' are inserted into the mother's vocabulary. Erica has demonstrated her awareness of *some* aspects of this discipline in her ability to respond with appropriate terminology and concepts to the nurse's question about what the baby has been doing "developmentally". That disciplinary process is then extended through the routine reproduction in talk of forms of "change".

3.3 Enrolling the parent's self-discipline

The interaction continues between this mother and nurse pair. In this section the nurse constructs a specific instruction for the mother based on Erica's disciplined rendering of how Loraine has changed since the last visit.

Fran: OK. (4.0) And she's sleeping through the night still?

Erica: Oh yeah /

Fran: / Good /

Erica: / no problem.

Fran: She seems to have a really nice disposition doesn't she?

Erica: Yeah, so far! **(laughs)** So far.

Fran: OK, and have you started to think about house-proofing your house?

Erica: Yeah, yeah. I've got everything up, up in the cupboards and stuff like that. I have to get some locks for the cupboards still.

Fran: Yeah, cause she's going to be mobile fairly soon so that's why /

Erica: / I've got some (...) and stuff /

Fran: / yeah. And just be *aware* with rolling, that, even if they're not rolling they can *grab* onto the edge of something and pull them, you know if she's on the couch by herself /

Erica: / yeah! /

Fran: / she could really grab on and then pull herself to the edge and then /

Erica: / Oh yeah, that's true. She could get leverage that way I never thought about that /

Fran: / yeah-h-h /

Erica: / She's got a play pen down stairs so I'll put her in that.

Erica's response to Fran's comment about the baby's 'disposition' suggests that she is already disciplined to 'know' that this could change--nothing is secure in the world constructed at the community clinic. The message recursively constituting this encounter is that children are in a state of constant change, this change must be watched and recorded by parents who must never become complacent and imagine that there is not some other aspect of the child's development to be closely monitored.

The 'reinforcement' from the nurse offers an opportunity for Erica to demonstrate her own self-discipline with regard to parenting. The mode of practice enacted at the clinic has an *effect* on Erica. Commenting on the encounter with Fran, Erica stated:

Erica: ... it's interesting that they ask what the baby's doing that's different from last time and stuff ... and sort of I don't know, I think to myself, well, then there must be more coming! There's more coming ... so it sort of encourages me.

Surveillance, relayed through mechanisms of audit, is re-established as a function of parenthood. The effect of getting the parent to watch for changes, for the "more" that "must be coming" has been accomplished through this particular way of conducting practice.

3.4 Issuing instructions: making 'moves'

Despite having complimented Erica for providing the responses she has, Fran moves on to re-state an alert pointed to earlier in the interaction. The conversational flow of this interaction is interrupted towards the end of this example. In the earlier interaction [p. 237 above], Fran alerts Erica to the baby's ability to roll over which may soon "surprise" Erica. This alert, importantly, interrupts the conversation. Several conversational turns later, Fran re-iterates the warning by legitimating her question about "house-proofing". Fran predicts that Loraine will "be mobile fairly soon". The alert is followed up with an instruction: Erica is instructed to "be *aware*".

The transformation of the child's body, accomplished with the technical assistance of the growth charts, again influences the nurse's position. Fran first locates the child's position within a particular developmental stage, making Loraine's behaviour 'predictable' for Fran. Loraine is first described as a member of the larger group of four-month old children: "they can *grab* onto the edge of something". Suddenly the pronoun shifts: "if she's on the couch by herself". The alert is issued based on the constitution of Loraine as being *individually* capable of combining her physical ability to grab with her ability to roll and, the real crux, to possibly harm herself. Fran appropriates discursive strategies informed by the institutional constraints of the clinic to give Erica an instruction to be alert to this particular danger.

3.5 Breaking in to instruct: appropriating accounts

Erica has given a disciplined account of her child's development since the last visit to the clinic. This account has been supplemented by Fran with disciplining prompts and guidance, alerting Erica to the institutional constraints on giving an account of development at the clinic. As part of this account Fran

has drawn out comments on Loraine's ability to "grab" and to "roll". A representation of Loraine is thus achieved whereby Loraine is described as a 'typical' four month old child who can grab and will soon be rolling. This 'ability' to roll is constructed as possibly 'surprising' for the mother--something that might happen at an unexpected moment. These elements are drawn together or 'appropriated' by Fran. She has 'created' an opening, a space, where she can 'break in' with an instruction for Erica to "be aware".

The instruction reflects a considerable amount of labour on Fran's' part. She has sought Erica's own rendering of her child's physical development, albeit, that this rendering is framed within 'expert' images of development: it is a 'disciplined' rendering. However, it is at the 'site' of such disciplined renderings of childhood development that the material for appropriation is located.

The "exchange" which Foucault credits with producing new resemblances are demonstrated in this example. The effect of bringing Erica's constructed account of Loraine's abilities out for audit and appropriation by Fran is to create "new resemblances". The new resemblance is that of Loraine as a child who is capable of falling from a height. The regimen brought in through the creation of this new resemblance involves increased parental surveillance.

Once a version of the child's development has been 'worked out', that is, constituted through the disciplined exchange between mother and nurse, the nurse achieves a position to instruct. Fran makes use of, appropriates, the parental account of the child's development. The instruction, based on the mother's own account, accomplishes a transformation in Erica's understanding of her child as a developing being: Erica will continue to 'watch' and, in even greater detail, monitor future change.

Significantly, it is Erica who, having already appropriated the nurse's instruction, offers the possibility from her own life-world of the "play pen" as a safe place for Loraine. Earlier, when Fran 'appropriated' the account, Erica had not yet been enrolled. Now, translating Fran's instruction regarding potential dangers for her child as in her own interests to attend to, Erica, now fully enrolled, offers up the play pen as a safe place for the baby. The possibility of the play pen arises from Erica's position in the encounter as one which can be

described as 'ready' to hear the nurse's instruction: she is primed in some way to hear and to accommodate Fran's instruction. This aspect of the parent's conduct will be taken up again in section 5.0.

4.0 The construction of 'needs': relating practice to parental concerns

Far from the 'rationalist' account of practice given to a parent where the reading of visible signs was said to direct the nurse to 'know' where to locate her health promoting efforts, the preceding example of clinic work points to a mode of practice centred around the appropriation of guided, disciplined accounts. As was raised in the previous section, Fran wants not just any account of Erica's child but a highly disciplined account. Fran sends out cues to guide Erica's account. Far from making an assessment of 'needs', this mode of practice points to a construction of 'needs'.

The construction of 'needs' operates as a duality: the nurse 'needs' a particular type of account (child development) in order to construct instructions to aim at the parent as a response to what stands as an 'assessed need'. 'Needs' represent both the medium and the outcome of the linguistic action (cf. Giddens, 1984).

Rather than demonstrating a 'rationalist' approach to work in the clinic, the implementation of 'need' as both the medium and outcome of linguistic work suggests an 'aural / oral' mode of conducting surveillance in this organized work setting. Such conduct stands in contrast to the 'visual' metaphor of surveillance pervading many accounts of nursing practice in the literature (Bloor & McIntosh, 1990; Benner, 1984; for a critical examination of the visual metaphor in a practice setting see Latimer, 1993).

4.1 The 'intrusion' of parental concerns

The routine, repetitive form of parent-nurse interactions in the immunization clinic arises to a considerable extent from organizational aids such as the assessment form used by nurses to account formally within the organization for each interaction they undertake (Appendix D). Using the form as an agenda for the visit, nurses effectively place limits on acceptable versions of

development. Helen talked about her perceptions of the form during an interview with the researcher:

> Helen: I tend to not leave it open right off the bat. Like I'm probably one of the faster nurses that keep relatively on time and yet because I can keep my time frame with covering what we need to know because I mean the bottom line is, I'm after all the information I need, you know, and dealing with mother's concern. So I want that out of the way.

Helen links the completion of the forms with keeping the interaction to a normative time frame. Helen accounts for taking twenty minutes with each parent-child group by pointing to the form. In addition to being a sign of work to be done, it also represents work which has been completed. The form is invested with organizational properties which run beside the knowledge-informing properties. The assessment form positions the nurse in time and space. Helen's account suggests that there is a 'danger' in "leaving it open". Helen's view of the danger is that she can get side-tracked by a mother who is permitted to raise concerns before the nurse has all the information needed to complete the form.

Within this account of work there is an expressed recognition of the possibility that the mother's concerns may not correspond to what the nurse "needs to know". Again, this calls into question the 'rationalist' account of practice as that which aims to 'clarify' problems the parent may be experiencing. Helen marks a difference between services rendered by clinic nurses and services sought by parents. Tensions arise in the work setting as a result of this difference. For instance, Helen comments on a recent evaluation of her work performance relayed to her by Sally, the assistant manager at the clinic:

> Helen: OK there was another instance too where I was visiting twins. One set of twin came out of the hospital early, I went and weighed, saw how she was managing, went back again when the next one came home. Always had lots of help. She knew what was going on. She was an intelligent human being that could call if there was a concern? But then we've got this set-up here at the office where they want to know satisfaction of the clients with our staff sort of thing so [Sally] gave me some feedback after she'd called this Mom and her comment was "Well, I would have liked to have seen her more often." So ... "She could have come more often" But that was never a voiced concern to me, for me to know that she wanted me more

> often and what did she want me for? Like what was the need? Do you know what I mean? So I mean when it's pointed out that that's "Well you could have been out there more often" **(laughs)** it sort of comes as a "So I'm not doing a good enough job" type of deal.

This account underlines the extent to which the concept of 'parental concerns' has entered into the discourse of the community health nurse. Helen's reaction to the "feedback" given by the assistant manager suggests that rules governing contact with individuals in the community are, in practice, ambiguous.

Sally relays the message that the mother of twins would have liked Helen to come to visit more often. Helen takes this as a form of discipline, that her assessment of the situation has been inadequate. Sally's "feedback" underlines the notion that nurses too are disciplined into preferred ways of practicing in the clinic. This discipline reinforces existing hierarchical structures as well as highlighting how these structures of domination are interpenetrated by structures of legitimation and signification. Helen's attempts to re-cast the 'criticism' of her performance is made by offering alternative readings of the home from which the 'complaint' arose. Helen legitimates her decision not to visit more frequently with an assessment of 'need'. In this particular instance, according to Helen's account, there was no 'need' for further visits.

4.2 Constructing 'needs' as a control mechanism

This raises a question regarding the relationship between 'needs' and 'concerns' as these are constructed in the clinic. Helen dismisses the 'complaint' as mis-guided. This is accomplished by deferring her position in the encounter as influencing the mother's work of framing a concern. The separation between spheres of operation of the mother and the nurse are taken by Helen to be complete. Deceived by her own rhetoric, she asserts the parent's position as not being influenced by her own.

However, as Helen's earlier comment about not leaving clinic visits "open right off the bat" suggests, the idea of 'parental concern' remains present for her: an example of the nurse's unsuccessful attempt to efface the social. Parental concerns are clearly something she exerts control over in order to work around them. How does this 'control' work in practice?

The intrusion of 'parental concerns' into the life-world of a community health nurse has a demonstrable effect on the position from which the nurse approaches interactions with parents. The discourse of 'concerns' positions nurses to feel the obligation to 'attend' to parents. That is, parental concerns "displace" the nurse. As the above account of work given by Helen suggests, nurses enact strategic mechanisms of control within encounters to accomplish work in a context where there is a constant 'danger' of 'parental concerns' arising. Helen accomplishes control over this aspect of work by "not leaving it open right off the bat". In the previous example of nurse Fran and mother Erica, alternative ways of "not leaving it open" are demonstrated. For instance, when Erica enters into a lengthy turn, Fran 'disciplines' Erica's account by asking a specific question:

Fran: Is she pick... is it the toys that she's picking up or more that she's watching?

Erica: Uh-h-h-hm, she's got a uhm, a thingamajiggy ...

Erica points at the ceiling.

Erica: ... a mobile! And uh, she really likes that and I've given her a mirror to look in, so the play school thing has a mobile on it, she loves that. She rolls it and she looks at herself and talks and ... **(laughs)**

Fran: OK. Is she rolling yet?

Erica: She's trying to (...)

The disciplined effect of questions such as "Is she rolling yet?" act on the parent in particular ways. Surveillance by audit serves to caution parents that their accounts are being attended to by nurses who, through their practiced, technical translations of 'development', reproduce 'expertise' upon which their position is maintained. What is suggested by this analysis of conduct is that power is not 'held' by the nurse but rather, drawing on technical aspects of the life-world, power is relayed through the encounter (see Latour, 1986). Power is 'experienced' by parents as they are 'moved' around (that is positioned) by the nurse's questions.

The mode of practice as it operates at the clinic points to the work of constituting 'needs' as the instantiation of a control mechanism. Nurses implement 'audit' as a way of appropriating versions of development which can then be drawn on to constitute a 'need'. The need does not necessarily 'exist' prior to the parents' entrance to the clinic, that is, typically a need was not observed to 'set off' assessment as the nurse's accounts of work suggest. Rather, 'needs' emerge through the disciplined conduct of practice in the clinic.

The nurse has not 'seen' the child in the sense that the rationalist discourse on practice suggests. It is important for the nurse in fact, not to 'see' the child in this sense -- for to see the child as a unique body is to undercut the networks upon which the nurse's position as expert rest. Rather, the 'site' within which the practice relationship emerges disciplines what the nurse 'sees'. This point will be expanded upon next.

5.0 Disciplining parental accounts

It has been argued that the intrusion of the notion of 'parental concerns' into the discourse of the community health clinic has an effect on the nurse's conduct. This effect has been described in the preceding section as a translation of 'concerns' into 'needs'. 'Needs', within nurses accounts are treated as though they enter the clinic as formulated by the client. However, as I have demonstrated above, 'needs' are constituted through the process of measurement and translation by a variety of technical means as the outcome of a particular 'gaze' which crucially, has as it's 'site', the parental account. Thus, nurses have accomplished a 'connection' between the parent's account and their action. It is only by examining the way in which the parents account is 'managed' by the nurse, the way in which it is calculated in Latour's (1987) sense, that it is possible to examine this process outside of the rationalist discourse pervading accounts of practice (for examples over the past decade, Calkin, 1984; Stainton, 1987; Morse, 1991a).

In this final section I want to turn to look more closely at the impact the version of practice illustrated in the preceding analysis has when the effects of practice engaged in during the encounter are examined. Of interest is to

demonstrate how the nurse's 'gaze' is appropriated by parents and what this appropriation suggests for their conduct in particular.

5.1 Surveillance as a condition of modernity

Strategies of surveillance are receiving increased attention within studies of nursing work as social conduct (Armstrong, 1982, 1983; Bloor & McIntosh, 1990; Tilley, 1990; May, 1992a, 1992b, 1993; Latimer, 1993; Mueller, 1993). Much of this work owes a credit to the work of Michel Foucault. Foucault and others have noted repeatedly that surveillance and the act of instruction are intimately linked in modern society (Foucault, 1975/1977; Giddens, 1984, 1991; Bauman, 1992a, 1992b).

Nurses at the clinic operate on the principle that the world outside is made up of a series of 'dangers' against which children must be protected. In practice, instructing a parent to "be alert" to potential dangers arising during their child's development is accomplished through nurse's work of 'preparing the ground' for instruction. Recalling the example of nurse Fran and mother Erica, this can be exemplified by the way in which Fran made the possibility of Erica's baby rolling off the sofa explicit.

> Fran: And just be *aware* with rolling, that, even if they're not rolling they can *grab* onto the edge of something and pull them, you know if she's on the couch by herself /
>
> Erica: / yeah! /
>
> Fran: / she could really grab on and then pull herself to the edge and then ...

Dangers are treated in this example not as self-evident but relying on explication by the nurse. The effect has been noted by Bauman (1992a) to be implicated in conditions supporting the propagation of expert groups, what he describes as "the cult of specialists" (p. 23). Erica is instructed to "be aware" on the basis of this imaginary scenario constructed by Fran. Importantly however, the instruction involves the appropriation of Erica's own observations of her child's development.

The effect of turning the surveillance function as a technical procedure over to the parent must be read as something taken on *in addition to* existing parental functions. That is, the effect of the visit to the clinic is to tag these particular forms of surveillance with a technical seal in that they have been suggested by an expert: the community health nurse. Of course, once incorporated into the parental function of caring for one's child, this technical form of surveillance will alter previously held understandings of parenting as a social construction. To the extent that previously held understandings of parenting do shift, the visit to the clinic represents an 'experience' in Gadamer's sense of the word. What Gadamer resists, but what this analysis demonstrates, is that such experiences evolve through significant "procedures of power" (Foucault 1977/1980, p. 148) exercised during the course of the visit.

Nurses work within grounds where knowledge about 'parenting' is, at best, contested. Lacking any secure 'rules' for informing a particular 'gaze' in the sense in which 'discourse' is treated by Foucault (cf. 1966/1970), these nurses demonstrate skill at accomplishing work which is not 'rule-based'. That is, there are no hard and fast rules of parenting within which these nurses operate. Instead, as the preceding example has demonstrated, nurses appropriate client-generated accounts of parenting in order to accomplish the significant shift in location for surveillance which was traditionally treated to be within the nurse's domain of responsibility. Clinic work, it will be argued next, is accomplished as an effect of "governmentality" (Foucault, 1978/1991).

Lacking any secure, 'rule-based' territory from which to enact her instructions to the parent, Fran transforms baby Loraine from a unique being into a 'typical' four month old child through application of measuring devices to Loraine's body. Then, Erica's parental 'perspective', which is not yet perhaps a 'gaze', is appropriated by Fran, increasing parental enrolment through translation of the nurse's technological 'gaze'. Loraine is now comparable with other children of her 'developmental stage'. The constitution of a 'developmental stage' creates a discursive space from which Fran can issue instructions. Defining Loraine as being located in a particular developmental stage, Fran creates space for work by investing Loraine with specific properties:

the ability to grab and roll. The specificity of the instruction acts to warn of a particular danger to the child and at the same time warns in a more general way against lapses in parental surveillance.

The important point I want to raise now and develop in the next chapter is that the governmentality effected through the nurse's actions arises, particularly in these conditions where there are no clear rules to be followed, in this instance, regarding 'proper parenting'. For Foucault,

> the finality of government resides in the things it manages and in the pursuit of the perfection and intensification of the processes which it directs; and the instruments of government, *instead of being laws*, now come to be *a range of multiform tactics* (1978/1991, p. 95, emphasis added).

The effect of constituting the child within a certain technological space is facilitated by the deployment of specialized devices deployed by competent practitioners. But it is not the child who is instructed. Rather, it is the parent. The child's body is not only transformed by technology but the effects of the technology applied to the child's body results in the instantiation of discipline surrounding the bringing up of children by parents. By tying the technology of measurements to images of parenting, the child's body as it is measured in the clinic is associated in particular ways with parenting actions.

5.2 Transforming accounts of spectacle to disciplined surveillance

To demonstrate the extent to which the nurse's disciplining instruction exerts governmentality effects by turning the surveillance function over to the parents, one further example is offered. The following extract arises part way through the counselling portion of the interaction. Unique to this encounter, both parents are in attendance. This 'fact' is useful to explicate certain features of the disciplining work engaged in by nurses in the clinic.

Susan and Paul have brought their four month old child, Jane, to the clinic for immunization. Jane has been crying on and off during the interaction and has been passed back and forth between Paul and Susan as they attempt to keep her from 'fussing'.

Paul has Jane lying on her abdomen balanced on the palm of his hand and he moves her through the air

like an airplane. The child is quiet now and she smiles as she moves through the air.

Diane: Does she ever like that. **(laughs)**

Susan: She likes getting airplane rides, eh?

Diane: She loves that.

Jane is being held upright now. She moves her legs up and down.

Paul: She's climbing steps.

Susan: (4.0) And we've got her in her jolly jumper now. She's been in there a couple of times. She doesn't know quite what to *do* , quite what to make of it but ...

Diane: (2.0) Do... how long do you leave her in there for?

Susan: Oh-h-h, just for a few ... maybe at the *most*, five minutes.

Diane: That's good /

Susan: / 'cause we're both sitting right there ...

Diane: Good.

Paul: She's a form of entertainment! **(Susan laughs)**

Diane: It's a nice diversion. Just when you're using that, just, you know, you've probably, it's probably in the directions to make sure just her *toes* are touching the ...

Susan: Right. Just her *toes* ?

Diane: Yeah, you don't want the whole heel to be hitting on ... that's too much of a *jolting* for the little hips /

Susan: / Oh! OK. /

Diane: / (...) age of the child ...

Susan: She has been on the *carpet* so it hasn't /

Diane: / it's a bit softer /

Susan: / been *too* bad but I'll remember that. **(looks at her husband.)** Maybe we should lift it up a little bit higher ...

Diane: Just so she can, uhm, you know hit, hit the floor and make something of it ... but it's not 'til around six months that the hips are *really* well formed, like the bone is-s until the cartilage is changing to bone, so you want to to be careful of any jolting ... (5.0) OK, we'll so ...

Diane turns from looking at the baby to her desk. She looks at the papers sitting in front of her then turns back to Susan.

Diane: Any teeth there yet?

The account of Jane's development has been prompted by Diane's question regarding what Susan and Paul had noticed as a change in Jane's behaviour since her last visit to the clinic at two months. The topic of the Jolly Jumper has been raised by Susan perhaps primarily to indicate parental encouragement of Jane's development. With the question "How long do you leave her in there for?" Diane signals that such 'encouragement' may also be potentially problematic. Diane's conduct underlines the aim of surveillance applied to parental accounts. 'Good' parenting can always have a down-side. Diane's comment warns these parents against complacency.

Diane's question introduces the notion of a 'time limit' on the use of a Jolly Jumper. This regulatory assertion has an effect on Susan's response which begins as a gloss, ("just for a few"), then becomes definitive ("at the *most*, five minutes"). Susan supplements her response with additional evidence of parental attention to the child ("we're both sitting right there"). For these parents, the four month old child learning to use the Jolly Jumper is constituted as 'spectacle'.

The effect of Diane's call to account on the issue of appropriate use of the Jolly Jumper exemplifies Foucault's comment on modern society:

> Our society is one not of spectacle, but of surveillance; under the surface of images, one invests bodies in depth; behind the great abstraction of exchange, there continues the meticulous, concrete training of useful forces; the circuits of communication are the supports of an accumulation and a centralization of knowledge ... (1975/1977, p. 217).

In this case, what Susan has expressed as a "surface", Diane instantiates as a "depth" which Susan's account of the Jolly Jumper has not fully considered. "Depth", as a version of 'development' constituted and informed by the technological 'gaze' of clinic workers, is implied in Diane's question. What has been a friendly "exchange" between parent and nurse regarding Jane's 'progress',

is 'covered' by Diane's efforts to "train" the parents so that they will go forward from this encounter as "useful forces".

Susan's response picks up on the regulatory frame, the "depth" in which the topic has been constituted by Diane's question. In addition, Susan supplements her account by underlining it with the parental supervision of this regulated activity. The call to account has an effect on the parents.

Diane makes further reference to the regulated nature of using equipment such as a Jolly Jumper. She points to "the directions" which, she suggests, the parents will have read. Diane does not ascertain in a direct manner whether or not the parents are aware of the directions nor whether these have been read. I would argue that it is significant that this is particularly *not* the way in which information regarding the directions is transmitted. The manner in which "the directions" are introduced into the talk represents another instance of what Foucault (1975/1977) refers to as "the meticulous, concrete training of useful forces" (p. 217). The function of pointing out particular aspects pertaining to the use of such equipment is to turn the obligation for its safe use over to the parents. The effect of the nurse's disciplining conduct, is to get the parents disciplined to apply surveillance over the appropriate use of the equipment.

5.3 Relays of discipline

Discipline is introduced through the nurse's attention to specific details, underlined during the encounter. In addition to the reference to time limits on the use of the equipment, Diane also points out that "toes", "heels" and that the child's "age" is to be considered. The child's body is constituted as a technical map, parts of which are to be monitored more carefully than others while using the Jolly Jumper. The nurse transforms the parents experience of the Jolly Jumper. From a spectacle, the Jolly Jumper has been transformed into a form of surveillance.

While the effect of the nurse's disciplining conduct is felt by the parents, that is, it 'positions' them, the location of discipline is in the object of the Jolly Jumper. No longer is it an object for play--it is now an object which the parents will associate with a number of rules for appropriate use. Their use of the Jolly

Jumper will no longer be purely for enjoyment but rather to enact surveillance over their daughter's development.

This transformation has important implications with regard to the nurse's position towards the parents. Having drawn on the specific examples which transformed the child's body onto the technical map, the nurse constitutes herself as an authority on this matter. As a message from an 'expert', the implication is that the parents could not have known about the state of the child's hips. The directions for using the Jolly Jumper then, are networked by Diane with her position as expert, reinforcing the significance of the trip to the clinic for 'expert' advice on equipment which previously the parents had understood to be unproblematic.

The effect of Diane's intervention regarding the disciplined use of the Jolly Jumper is immediately apparent. Susan turns to Paul and 'relays' the nurse's disciplining talk with discipline of her own. Here is an instance of the parent 'appropriating' discipline issued by the nurse in order to relay the message to her husband. When Susan turns to Paul and states that "Maybe we should lift it up a little bit higher ..." the discipline has been turned in upon itself. Susan instantiates a networking of self-discipline.

The nurse's work in the clinic has been accomplished. The function of protecting the child against any number of dangers in the home has been turned over to the parents. Susan and Paul have been positioned by the nurse's questioning of their use of the Jolly Jumper. In making their response to her, they acknowledge their obligation to 'take care'.

Diane has moved them from their position as 'good' parents who encourage their child's development into positions whereby they will investigate the Jolly Jumper as a potential and constant danger to their child.

6.0 Institutionalizing forms of health promotion

In this chapter I have argued that the basis of practice in this clinic are not enacted in a rationalist manner as nurse's accounts might suggest. Instead, audits made of parental accounts of childhood development are constituted by nurses as a 'site' for work.

The transformation of the child's body accomplished with the technical assistance of the growth charts influences the nurse's position in the encounter. The measurements make the child predictable for the nurse. The facility offered by measuring the child, is linked with a message which recursively constitutes encounters at the clinic, that is, that children are in a state of constant change and that this change must be closely monitored by parents.

Parental accounts of their child's development are guided or instructed by nurses in order for the nurse to construct 'needs'. The parental account therefore represents the 'site' of disciplined renderings of childhood development. The account is the location of the materials available for the nurse to appropriate in the form of disciplining instructions for parents to monitor the change in their children.

To some considerable extent, the 'institutional constraints' framing conduct in the clinic are conditioned by the use of the 'aural / oral' mode of enacting surveillance in the clinic. This form of surveillance is facilitated by the parent's position in relation to the nurse in clinic encounters. As has been demonstrated above, parents come to the clinic *already disciplined*. While there are aspects of the process of instantiating the discipline of parenting which might be said to represent a 'discourse', it appears that rather than framing the nurse's 'gaze' and in turn her action towards the parent and child, discourses such as 'development' and 'safety' are appropriated by nurses as *facilities* for work. In this chapter I have raised the possibility for reading the 'end' of this work as a "governmentality" exercised by the nurse over future parental conduct.

Drawing on discourses as 'facilities' to enact work, nurses at Hillcrest Clinic have instituted a new institution: the community clinic. In the following chapter I will examine this 'new institution' in greater detail. In particular I am concerned to illustrate how nurses exercise governmentality through the use of particular "tactics" (Foucault, 1978/1991, p. 95). I will illustrate how such tactics, or 'practices', as they will be developed in chapter nine, are 'supported' through the networking of interests inherent in the constitution of practice in particular ways.

CHAPTER NINE

Institutions for Conducting Health Promotion:

bringing practice to the clinic

> Society is not what holds us together, it is what is held together.
>
> B. Latour, The Powers of Association, (pp. 276)

1.0 Introduction

The concept of 'institutions' and the processes of institutionalizing practices have punctuated the discussion in the preceding three chapters. In this penultimate chapter I will foreground this notion in order to draw the analysis of research materials together. The aim is not to offer solutions to the processes of institutionalization. Rather it is to suggest how relationships in the clinic can be understood as being constituted in particular ways, that is, informed by particular 'institutions' operating in society at large and given expression in the clinic. The implications of such institutions on the nurses' conduct will be explored particularly as it relates to the forms of health promotion it produces and reproduces.

1.1 Measurements

The place of measurement in community nursing practice was raised in chapter seven as having significant influence on conduct in the clinic. The measurements taken of children prior to each counselling session is not, as I have argued, merely functional. That is, the measures do not only provide the nurse with materials for instruction. Measurements are also implicated in the

semiotic transformation of a qualitatively unique human being into a body amenable to the working conditions favoured in the clinic.

The effect of drawing these measurements into practice is that a frame is applied to the child's body, a frame which the nurse recognizes as familiar. No longer is the child unique and therefore 'unknown'. Rather, because the nurse 'knows' about the child through the measurements, she can approach the child facilitated by this particular form of knowledge. However, it is important to recognize that the approach takes place only through a deferral of other forms of representation (Latour, 1987). So, while measurements *facilitate* the approach to the child, they facilitate it by slicing away other experiences which parents attending the clinic may have of their child.

The transformation has a direct effect on the relative 'size' of actors in the clinic (see Callon & Latour, 1981). The nurse's ability to apply the standards associated with her measurements onto the child's body puts her in a position to interpret what the measurements mean and how they will be used during the interaction. Understanding this transformation as a semiotic one points to the underlying importance of attaching meaning to signs. The child's body, represented through specific signs such as weight, height and head circumference, importantly signs applied by the nurse using her technology (with the parent as assistant), puts the nurse in a strong position not only to influence how the signs are to be read but the extent to which the readings are considered valid. The taking of measurements plays a significant part in confirming the asymmetrical nature of the practice relationship.

Taking a wider view on these measurements not merely as 'establishing' a relationship but 'confirming' a relationship informed by larger structural features of modern society, the view taken in this chapter is that the structural conditions operating in the society of which this study is illustrative, are 'right' in that they facilitate the shift in representations of children from qualitative to quantitative beings and the shift in the relationship between the nurse and client as asymmetrical. In this chapter these conditions, understood as 'networked interests', will be explicated.

1.2 Audit

In chapter eight I argued that the 'site' of work in the clinic was the parental account, audited by nurses during counselling sessions. Parental accounts, organized within a discursive space of 'competing messages' are contextualized by mutual obligations to account and to attend to the accounts given during clinic visits. As part of the audit, 'parental concerns' are constituted as 'needs' through interaction.

Movement between 'concerns' and 'needs' suggests a hinge-like mechanism. On one side 'concerns' are formulated and drawn on by the nurse as she audits the account given by the parent. Pulling the concern through the audit facilitates the giving of instructions by the nurse. On the other side of the hinge, now transformed as 'needs', the effect of the instruction on the parent is to alter their understanding of child-care activities, for instance by transforming spectacle into forms of surveillance.

1.3 'Conversation' as a preferred mode for enacting practice

In this chapter I want to return to that feature of work first pointed to in chapter six as 'unusual'. In chapter six it was suggested that clinic visits were conducted in the form of 'friendly conversations'. In the preceding two chapters these encounters have been excavated as purposive work. While work was treated by workers as purposive, it was repeatedly accounted for by consumers of this service as 'non-work'.

In this chapter I want to explore this unusual feature of work to suggest how, as a mode of practice, 'conversation' has played a significant part in accomplishing the shift in preferred work locations from the community at large to the clinic. I will also examine how that shift to the clinic facilitates the work engaged in by nurses. Two central notions will organize this discussion.

First, the notion of the life-world: both that of the clinic and that of the home, in particular as the term refers to those structural aspects which contextualize conduct in particular locales. The aim is to underline the extent to which conduct in the clinic has an effect on parental conduct in the home. I will not make assertions regarding 'appropriate' levels of influence. Rather, the aim

is to explicate and illustrate the ways in which practices enacted in the clinic cuts across life-worlds, influencing both the nurses' life-world and the parent-child life-world in particular ways.

Secondly I will address the importance of the clients' position in the mode of practice enacted at the clinic. That is, the client is understood within this thesis as mutually implicated in the shift of preferred work locations from the home to the clinic. The concern is to explicate how this mode of practice cannot be understood as emerging independently of those members who are understood as 'consumers' of the service. Practice, as it is constituted in the clinic, will be discussed as a 'networking of interests'.

2.0 Legitimating boundaries around work spaces

The discussion begins with an exploration of one particular example of conduct where there was evidence from the measurements taken of a four month old child that more intensive surveillance could have been instituted. Marcia and her four month old baby, Kim, had been seen by clinic personnel on three separate occasions. The first contact was at a home visit, then in the clinic at two months. The third encounter was observed during the fieldwork. The child's weight was found to have decreased in relative terms as measured by the percentile graph. Earlier, it will be recalled that nurse Fran advertised the purpose of the graph to be that of an "alert". If the weight was 'seen' to be dropping progressively, staff members would take this as an "alert" that they "should be watching ... seeing what's happening". This particular case then offered just such an 'alert'. Yet, no follow-up was suggested nor instituted.

The aim is not to determine 'what went wrong' but rather treat the case as an instance of how prevailing images of work are brought to bear on such 'problems' in order to enact the "watching" from the clinic itself. As a negative case of clinic policy, the example can be used to further demonstrate the extent to which audit stands as the central 'site' of practice.

2.1 Constructing a 'need'

The sequence of the visit was no different than any other observed at the clinic. Measurements were taken out in the waiting room and then Marcia was invited by Helen to enter the private office. In an interview immediately following the encounter, Helen suggested that the measurements were important in her understanding of the 'problem':

> Helen: See, it started above the fiftieth, levelled to just above the twenty-fifth, now it's just above the tenth.

These results, in conjunction with the audit of accounts arising during the encounter, position Helen in a particular relation with Marcia. Helen compares Marcia with mother Ann, whom Helen had also 'counselled' on this particular day:

> Helen: This last one's more insecure as to how things are going. Obviously doesn't pick up on things right away.

It is important to note that the three results to which Helen refers were obtained under quite different circumstances. While the second and third were obtained at the clinic, the first was a 'birth weight'. Typically, this weight represented the measurement taken at the child's birth, transferred from the birth record obtained by community nurses from the hospital where the child was born.

The 'conditions' surrounding the measures are not questioned by either member in the encounter. 'Safe' inside the black box, Helen makes claims about the results and her 'impressions' of Marcia's parenting abilities from her position well on top of the black box. The 'location' of the technical measurements, in the black box, has implications for Helen's asymmetrical position in relation to Marcia.

Helen begins the visit with her version of the technical measurements, in the form of test 'results', to Marcia.

> Helen: OK, let me show you where she's at here. She's ... moved down a *little* off the seventy-fifth to just above the fiftieth for *length* ...
>
> Marcia: Um hmm...

Helen: She's slowed up a bit. She didn't *gain* a tremendous amount here. She's moved ... on the tenth percentile /

Marcia: / Oh! /

Helen: / and she was on the twenty-fifth so ... Has she been ill or not feeding as good or just really activity changed that she's just really more and more active?

Marcia: Yeah, I find that she's really more and more active.

Helen: Yeah, she's *burning* those calories.

Marcia: Yeah, she used to sleep a *lot*. She used to sleep, you know, eight to ... well, no, actually from about nine o'clock to about seven and then /

Helen: / ten hours /

Marcia: / ... yeah from about eight to twelve. From one to four and *now* she's starting to, you know /

Helen: / Not sleep as much /

Marcia: / Yeah /

Helen: / and so she's burning more of the ... /

Marcia: / Yeah, the nights more is, is the same but the morning is just two hours and then in the afternoon maybe an hour and a half /

Helen: / Ah *ha*!/

Marcia: / so ...

Using the graph to 'show' Marcia the changes, Helen makes a series of moves beginning with the height and then the weight measurements: showing by saying what she sees. Marcia expresses surprise at this information. Helen offers a number of labels for 'problems' which might offer work space for the visit: she suggests that Kim might have been "ill" or "not feeding as good" or that her "activity" level might have increased. The way in which measurements are treated like correlations with a foreshortened version of development is apparent. Helen 'secures' a cause ("more and more active") for the problem by offering Marcia a menu of options.

Helen's 'view' of development is tightly coupled with the growth chart. As a device for structuring the clinic visit, the chart's most narrow use is employed to quickly set up boundaries around a 'problem'. The problem of insufficient weight gain rests entirely on the technological device of the graph to provide visible 'evidence' of the status of the problem. Drawing on Marcia's 'account', Helen identifies the cause for this problem, increased activity, and then supplements Marcia's account with a technical account of the problematic weight gain ("she's *burning* those calories").

Once 'activity level' focuses the discussion, Marcia supports the construction of the problem by providing further accounts of Kim's behaviour in the home. Sleep is raised as a prime indicator of activity levels. Marcia supplies 'disciplining guesses' regarding Kim's activity level. Her comment about Kim sleeping "a *lot*" is supplemented with timed 'evidence' of how "a *lot*" is defined. In subsequent turns at conversation she gives a sleep timetable interrupted by Helen's running tally for total number of hours slept. Finally Helen 'announces' that the problem has been sufficiently constructed: "Ah ha!" punctuates the move to the 'instruction' phase.

2.2 Instruct-able problems

The nurse's work involves 'pulling a problem through' by attending to cues appropriated from the parental account. These cues are 'recognizable' to the nurse as ready-made. The audit of Marcia's account produces evidence of what Helen has already constructed as a problem *because she already 'knows' a solution*. Input from the parental account gives the 'problem' local significance. 'Local' must be understood as local to the clinic. The construction of a workable problem has not taken account of the home context. It reflects structures informing 'work' in the clinic. As feeding advice is one aspect of 'work' in the clinic, a problem is structured around the notion of a child who is burning excessive calories. The nurse establishes space for work. For instance, Helen's 'instruction' to Marcia was to begin feeding Kim solids immediately:

> Helen: OK. Now I'll tell you what they said last time and you tell me what's new. OK, they've put down that she was breast

on demand. What do you notice that she's levelled out to? How frequent are her feeds now?

Marcia: Uhm, (2.0) yeah they're, (1.5) let's see, (3.0) twice in the morning and (3.0) three ... three or four in the afternoon.

Helen: OK, so there's about ... six feeds and then does she feed at night time?

Marcia: No, she goes right through at night.

Helen: Ah-h-h, (4.0) OK. And **(sighs)** were you going to consider some solids in the next little while?

Marcia: Yeah, I was thinking at ... maybe at five and a half or six months.

Helen: OK. See how she does with her nursing. If she still keeps pipped up there as far as not settling down, just because her weight is, is, is dropped that *bit* so that it's well *below* what her height is I might say, even though she hasn't made that six month mark, now's an ideal time to get some extra calories in her /

Marcia: / Oh! OK /

Helen: / Yeah. *Not* so that it affects her nursing.

Helen's question regarding the feeding regime disciplines Marcia: Helen suggests that as the mother of a five month old baby, Marcia should have Kim on a particular feeding regime and that Marcia should be able to rehearse this regime with the nurse. A measure of the child's satisfaction is deferred in favour of the 'discipline' of a feeding regime.

The 'problem' is located by particular means deployed through the interaction. The 'problem' is not located in terms of possible signs which Marcia has noticed (other than the one of increased activity which the problem was initially constructed around), but rather with direct reference back to the measurements. The instruction to feed Kim is legitimated by Helen "because her weight is, is, is dropped that *bit* so that it's well *below* what her height is". The weight 'loss' is made visible by reference to another measurement -- that of height. The 'problem' is defined and sustained through reference to the measurements. It is constructed within structures of signification pertaining to the life-world of the clinic, legitimated with reference to the life-world of the

clinic and dominated by an agent who derives her identity as an 'expert' member of the life-world of the clinic. There is no indication that Helen takes advantage of, that is 'appropriates' any aspect of Marcia's life-world to construct the 'problem'. As will be illustrated below, this may have implications for how the problem is treated once Marcia returns home.

2.3 'Abstracting' problems in the clinic

The effect of the process illustrated in the above example is to 'abstract' (cf. Latour, 1987) aspects of conduct away from the life-world in which they arise. In this case, abstracting involves a construction of a problem which draws entirely on structures informing work at the clinic. Abstract should be understood not in its adjectival sense, that is, as a description of a cognitive process engaged in by the nurse. Rather, 'abstract' is used as a verb; it underlines the nurse's 'moves' as actions which accomplish a particular state: the formulation of a instruct-able problem. For instance, Helen abstracts Marcia's faltering account of how frequently Kim feeds into more precise language of the clinic ("OK, so there's about six feeds").

This clarification is important as I do not wish to suggest the description of a cognitive process but rather an inter*action*al one. 'Abstracting' accounts in the way described above represents 'typical' conduct in the clinic. The effect of this process of abstracting problems is that problems are then 'wrapped up' in clinic devices: devices for 'seeing' them as problems and devices for 'solving' the now visible problems. Thus the abstracting action of these encounters represents a central aspect of the nurses' expertise in the clinic. The nurses' ability to abstract problems from the audit of 'concerns' facilitates her ability to instruct during the encounter.

The clinic record represents an aspect of clinic materiality which supports the abstracting of problems in the way described. The signature at the bottom of the "Nursing Notes" form (Appendix D) indicates more than a record of treatment; it represents the child's presence in the clinic. As such, work in the study location is somewhat unique when compared with findings from other similar studies conducted in hospital settings (see Latimer, 1993; Mueller, 1993).

In hospital settings there is some indication that the written form has taken precedence over the verbal with regard to accomplishing a position from which claims about work are made. Latimer (1993) has investigated the effects of the nursing process as a structure which informs the 'gaze' of nurses working with acutely ill geriatric patients. Her findings suggest that while the nursing process has not accomplished its goal of 'patient-centred' care, the enactment of the nursing process through primarily written aspects of work on the ward, are privileged by the nurse over work available for conduct at a verbal level. For instance, an elderly patient's request for a drink is deferred by the nurse in order that an admission form can be completed.

While nurses at Hillcrest Clinic completed the "Nursing Notes" form on every child attending for immunization, this was observed to have ceremonial rather than ritual implications. Ceremonial refers to the sense used by Turner (1967). That is, completing the forms marked a passage through time, not a transformational event for nurses. The notion of 'abstracting', again in its sense as a verb, is illustrative of this work. Operating from parental accounts, phrases and words are 'appropriated' or abstracted away from the account and inserted in particular sections of the form.

Treating the clinic record in this way constitutes individual visits to the clinic as discrete events with the clinic record acting as an artifact of continuity which in practice is treated as a clinic 'myth'.

The clinic record, as an artifact, is a sign to parents attending the clinic that information is being accumulated and recorded over time. The record is, however, simply that: a clinic artifact. It has little bearing on understandings once the client returns to their own life-world. Clinic artifacts may serve important 'locating' functions inside the clinic. However, returning to the life-world of day-to-day child and home care, parents were observed to draw on quite different material forms to re-contextualize instructions received in the clinic.

2.4 Re-contextualizing abstract instructions

At an interview in Marcia's home two weeks after her encounter with Helen in the clinic, Marcia gave some indication of how she had 'worked out', or re-contextualized, the instructions given to her:

> Marcia: Yeah, I did take her advice in feeding her rice pablum. I started that and she seems to be taking it really good so I must have been doing that for the past, it must be going on two weeks.
>
> MEP: And have you noticed any change in [Kim]?
>
> Marcia: Not really, not in weight wise like I don't think her legs are chubbier or anything but she's a little bit more active so maybe it is giving her a little bit more energy and helping her to grow.

What Marcia "notices" as a difference is "not in weight wise", pointing to what she may have expected as a visible change but that Kim is "a little bit more active". Marcia concludes that this may be attributable to the food, understood as giving Kim "more energy".

The discrepancy between the 'cause' constructed by Helen in the clinic as to why Kim was not gaining sufficient weight and Marcia's measurement of 'success' of the remedy must be taken seriously. In response to Helen's menu of reasons why Kim's weight had not increased as expected, Marcia stated that she had noticed that Kim had become much more active lately. However, back in the life-world of Marcia's home two weeks later, Marcia notes that since she has been giving Kim the cereal, Kim is "a little bit more active".

Earlier in this follow-up interview, Marcia had pointed to some of the "stresses" defining her life-world as a wife and mother of two small children:

> Marcia: It has been a little stressful, you know, mentally because my husband doesn't have a job so it's you know, we're thinking of ways trying to get rent together and you know things and yet kind of really maintain a character, just hold ourselves together and of course having the little one **(Andrew)** being so demanding. [Kim] is quiet, she just occupies herself and does a little bit but he **(Andrew)** is really demanding and he likes a lot of attention and I find a lot of, I guess maybe rebellion in a way that he doesn't feel like he's getting enough attention.

It should be noted that this account was stimulated by the first question asked at this interview. An 'opening' question was asked regarding how Marcia presently viewed her state of health. It took very little prompting to surface the account. I would argue that it was, therefore, an account which was available to Helen.

The important point I wish to underline is not that this account is more 'valid' than the one obtained by Helen in the clinic but that it reflects an account of the life-world stimulated by different institutional constraints than that of the account arising in the clinic. That is, the structures constraining, but also, and significantly enabling the above account of 'stress', are different from those structures information the account given to Helen in the clinic regarding how Kim had been feeding.

In light of the "stresses" defining her perceptions of the home environment, it seems reasonable to suggest that Marcia may not have noticed a "pattern" to Kim's feeding at all. It will be recalled that when Marcia was asked by Helen in the clinic what Kim's "feeds" had "levelled out to", Marcia was left struggling to provide an account.

In contrast to that account of Kim's feeding regime (framed by the life-world of the clinic) the account provided above suggests that Marcia and her husband are struggling to "get rent together" and "just hold ourselves together". Marcia describes her two year old boy, Andrew, as "so demanding". Kim, on the other hand, is described as "quiet, she just occupies herself". Given this description of their home situation, I would suggest that in the turmoil of the day-to-day struggle of keeping the family's collective head above water, Marcia has simply not noticed Kim's growth patterns at all. She is a quiet baby amidst the stress and demands of Marcia's life-world. Being a quiet baby, Kim is gaining weight at a very slow rate because her 'requirements' are not being heard above the other demands Marcia is bombarded with on a day-to-day basis.

The discrepancy in Marcia's account can be commented on further. As an effect introduced by the research design itself, this 'account' is stimulated by the connection between myself, as the researcher, and the clinic visit where Marcia and I first met. Under ordinary circumstances, an account of the clinic visit would not be sought, although a comment from a neighbour or friend may

stimulate a similar sort of account. I recognize that my close connection with conduct at the clinic may have an additional influence on the client's attempts to remember the visit, to recall it: to re-visit the visit. Thus, the discrepancy is not as significant for its relative 'inaccuracy' as it is for its sense of 'accommodation'. The problem constructed within the life-world of the clinic has been re-contextualized in Marcia's account two weeks later into the life-world of the home. As a result, difficulties in 'fit' arise, compromises are made to definitions applied in the clinic, and a 'new', accommodated account of the child's status is available to the parent for use when someone calls on them to account again.

3.0 Making accommodations in the life-world

What the fore-going analysis of Marcia's visit to the clinic and my subsequent visit with her in her home suggests is that parents engage in a significant amount of work around the time of the visit to the clinic to prepare themselves for the giving of accounts and then afterwards, to make some form of accommodation for the account of their life-world defined at the clinic. The account defined in the clinic may contrast radically with their own understanding of the day-to-day life-world.

In chapter six this 'preparation' was discussed in terms of 'obligations' on the part of the parent to give accounts and on the part of the nurse to attend to that account. This, it was argued, arose from readings of the clinic setting as a regionalized space (Giddens, 1984). I am suggesting a preparation which is, in effect, well prior to that informing these obligations. This state of preparedness undoubtedly influences the readings made of regions in the clinic.

In the following sections I will explore this notion of making 'accommodations' and relate this to the analytic frame informing discussions regarding this practice setting in preceding chapters. Taking a step back, accommodations will be examined as effects of a wider disciplinary process implicated in the formulation of the life-world which influences members' relative size (expert / non-expert) with regard to one another when encountering one another in various locales pertaining to clinic work. An explanation of how conduct such as that observed between nurse and client members in the clinic

can be understood which retains the notion of work as a mutual accomplishment will be offered.

3.1 'Fracturing' the parents' life-world

While the predominant location for encounters between nurses and clients is the clinic, even where the nurse does venture out into the community, such as to conduct a Senior's Drop-In clinic at a local Senior's residence, the manner in which the room is re-arranged and the way in which visits are organized suggest only a transfer of the life-world of the clinic to a different location, not an accommodation for different life-worlds.

For immunization clinics, parents bring children to the nurse. The significance of this action should not be lost in the detail of the visits themselves. The atmosphere of the clinic, friendly but efficient, offers several contrasts with the atmosphere of the home. This will be illustrated with reference to the home visit observed during field world. Observations arising from that locale point to recognizable differences in 'preparation' for the nurse's visit compared to those undertaken for my return visit two weeks later to conduct the follow-up interview.

It was arranged with Paula, the mother who was to be visited in the home by nurse Helen, that I would arrive ten or fifteen minutes ahead of Helen's scheduled arrival. This was to allow time for the study to be reviewed with Paula and consent forms to be signed. Arriving ahead of the nurse then, I observed Paula quickly putting a vacuum cleaner away before coming to the door to great me. Paula's three week old baby boy was propped up with pillows on the sofa. Both Paula and her four year old daughter had wet hair suggesting that they had recently washed their hair.

When I returned to do the follow-up interview two weeks later, I found the house with curtains drawn over and no sign of anyone around. After two rings of the doorbell Paula answered wearing a dressing gown, hair tousled as though she had recently arisen from her bed. She seemed surprised at my suggestion that I could return later if it would be more convenient. Instead, she asked me to enter and the interview began.

The clean, tidy appearance of the living room had changed drastically in the intervening two weeks. Pillows from the sofa where the baby had been propped up were no longer in evidence. Clothing was strewn around the room. Paula made no effort to 'clean up' the living room for my visit. Paula's preparation for Helen's home visit reflects an aspect of disciplined conduct and marks the 'fracturing' of her day-to-day life-world to accommodate the nurse's visit. This 'fracturing' of the life-world is clearly influenced by Helen's anticipated arrival but the important point is that Paula enacts it: she fractures her own life-world in particular ways in preparation for the encounter.

Similarly, the act of bringing children to the clinic fractures the client's life-world. I am not suggesting that this 'fracture' is to be understood in a wholly negative sense. Paula enacts surveillance on her own conduct, that is, her conduct suggests the performance of 'self-discipline'. She prepares her home and evaluates her work by taking the position she 'guesses' the nurse holds. Thus cleanliness and efficiency are expressed. After cleaning up the house, the older child waits with her mother and baby brother. When the nurse arrives, the child is sent off by Paula to play quietly elsewhere: again, the family's life-world is fractured as a part of the experience of being visited in the home by the nurse.

3.2 Expressions of the life-world

A significant difference was noted between the home visit and those contacts observed between nurses and clients (for instance, immunization clinic, Senior's Drop-In, school immunization clinic). It is in the home that the client role is at its most obscure. It is the client who arranges seating, offers refreshments, and is interrupted by telephones and door bells. To a much greater extent than in any other practice setting, the nurse is displaced by operating within someone else's time and space regions. The regionalization of the home provides the parent with an advantage, primarily, I would argue, because of the "presence availability" (Giddens, 1984, p. 118) of materials facilitating access to the client's own life-world. An interview conducted with Helen following the home visit gives some indication of the sense of displacement such availability of material aspects of the home has on the nurse.

During the visit Helen had made a recommendation that Paula should lay the baby on his abdomen after feeding him. This instruction was suggested as a way of getting the baby to sleep for longer periods between feeds. Helen reported during the subsequent interview that she did not have confidence that this instruction would be followed through by Paula. Commenting on the written transcript of the visit Helen gave the following account of her meeting with Paula:

> Helen: (...) that one instance you remember she put him on his tummy to start with and then as it kept fussing she went over afterwards and I see by the notes that she did turn it more to it's side. OK, I can justify that and say, "OK, she's listening. She's got people there, she doesn't want him fussing so that's not a good way of saying, yeah, she's not going to try it?" But, I wasn't comfortable saying that she would have gone ahead and followed through.

The presence availability of Paula's life-world results in insecurity on Helen's part. She does not feel "comfortable" that her instruction will be taken up by Paula.

The account points to a significant difference for nurses regarding their understanding of 'work' in the various locales where they conduct themselves as community nurses. Shifting the 'site' of practice from observation to the audit of client accounts, a shift suggesting a radical turn *away from surveillance* of the 'visible' *toward a cross-checking of reportable conduct,* marks a significant re-location for 'action', a re-location which takes account of the effects for nurses' conduct on differential levels of presence availability of the parent's life-world.

This significant point will be given further attention. The possibility that Paula can disregard Helen's instruction suggests that Helen is working within a space where there are few rules for 'correct' parenting behaviour. Such conditions find sympathy in Foucault's distinction between sovereign states and the "art of government":

> 'the common good' refers to a state of affairs where all the subjects without exception obey the laws ... the good is obedience to the law, hence the good for sovereignty is that people should obey it ...

> Now, with the new definition given by La Perrière, with his attempt at a definition of government, I believe we can see emerging a new kind of finality. Government is defined as a right manner of disposing things so as to lead not to the form of the common good ... but to an end which is 'convenient' for each of the things that are to be governed (Foucault, 1978/1991, p. 95).

The possibility that parents may refuse an instruction suggests, not only that arguments designed to regulate health through the development of 'laws' may be largely anachronistic for a modern society, but, more importantly, opens the possibility that where the nurse's instruction *is* followed, one can expect to find, not a docile obedience to a 'common good' but rather, an intricate series of relations which lead members to follow the instruction presented as a 'convenience'.

Returning to the notion of 'translation' in Latour's sense (1981, 1986, 1987), a 'procedure of power' emerges in which, drawing on particular "tactics" (Foucault, 1978/1991, p. 95), such as conversational techniques, the generation of parental accounts of development by nurses in the community health clinic can be understood as a form of governmentality. Tracing a child's development represents a location where both nurses and parents have an 'interest': the nurse in recording such development and the parent in having development confirmed. Here are the grounds for translations to occur. As "experts in normality" (Foucault, 1975/1977, p. 228), nurses situate themselves in particular ways, that is, within a discursive space of 'competing messages'. Parents come to the clinic in a 'stripped-down' version of their day-to-day life-world of child-rearing ready to produce accounts of parental conduct. Rather than employing visual surveillance, linked to the existence of 'laws' for the common good (cf. Foucault, 1978/1991, p. 95), nurses at the clinic 'cross-check' reportable conduct as a means of effecting governmentality in the 'site'. The 'convenience' of having development confirmed by clinic workers means that clients fracture their own life-world, as a form of translation, by the very approach to the clinic. Parents position themselves in relation to the nurse as if they wish to fulfil their own interests.

3.3 Methods for work -- methods for research

The parallel between the methods of cross-checking reportable conduct employed by nurses and those used by myself as researcher, is also important to note. As argued earlier, the conditions surrounding the access of accounts of conduct from members of a research setting are the same as those used by members in day-to-day encounters. While I am not necessarily suggesting that the methods employed by the nurses in this setting are as robust as those used by myself as a researcher conducting a field study of the setting, it is significant to note that nurse's draw in particular ways on the *potential* and *availability* of such methods. The relationship between observation and audit might therefore be expanded on in order to clarify how it is that I have used these as research methods by examining their use in practice.

There is a sense in which observation and audit represent materiality in two incommensurable ways. That is, what we see is not necessarily what we hear; these two sensory mechanisms capture qualitatively different sorts of material. From a research stand point, when observation and audit are used as cross-checks for one another, differences can be marked and followed up with further observation and audit.

The example presented earlier of nurse Diane and her observations of the "cute, young little mother" she encountered in the waiting room suggests how nurses use observation and audit to signal difference also. However, rather than taking difference as a signal of something to 'follow up', in that particular instance the difference was re-presented to the mother as an 'inappropriate manner'. Diane used conversational techniques to 'lighten' the encounter, so that she could proceed with work.

3.4 Authority over 'work' in the clinic

The 'clean' and 'efficient' mode of work operating in the life-world of the clinic has, I have argued, a significant bearing on the nurse's position to dominate in the relationship as it is constituted in the clinic. Whereas Helen still accomplishes the instruction to Paula to place her baby boy on his abdomen after feeding, Paula's action of turning the baby to his side as soon as he made a sound

moves Helen. *She "justifies" Paula's action*. Underlining the extent to which Helen takes her position as an authority on child-rearing advice for granted as she enters the home, Helen is compelled to 'account' for Paula's action. She makes representations of Paula. However, surrounded by the materials of her own life-world, Helen's authority over Paula is attenuated in the home visit. The attenuation of authority has implications for Helen's conduct. It produces problems such as 'insecurity' and 'discomfort' regarding the probability that the parent will take up instruction.

Contrasting with this attenuated version of the nurse's authority to issue instructions is the more 'economic' model typically observed in the clinic. For instance, consider the example of Ann who brought her four month old baby in to the clinic for immunization accompanied by her two year old son, Mark. Throughout the visit Mark interrupted frequently. Helen dealt with Mark's interruptions by giving him some crayons to play with while his mother and Helen were "talking". Helen's disciplining 'move' to defer Mark's interruptions were reinforced by relaying that discipline through Ann. Ann 'picks up' the 'move' made by Helen and re-deploys it on her son.

Helen's position as 'expert' is reproduced through Ann's conduct which keeps talk reasonably clear of Mark's interruptions. For example, throughout the remainder of the visit Ann continued to direct Mark back to his colouring when he interrupted. Helen remained silent, maintaining eye contact only with Ann. In this way Helen accomplished the discipline of Mark by relaying it through Ann:

Helen: (2.0) Did he have a cord defect? Did they mention anything with your cord /

Ann: / No. /

Helen: / that there was only two vessels?

Ann: No, no. It was all three vessels. It was all normal.

Child talking and playing with a toy on the edge of the desk during this section. Ann and Helen maintain eye contact.

Ann: Can you colour for me please? **(leans over to whisper)**

Helen: (4.0) It's just I remember I had a cord defect once /

Ann: / Is that right? /

Helen: / and he went for all the renal scans and everything /

Ann: / Yeah /

Helen: / and ultrasounds too because they felt there was a risk there of there only being one.

The effect is that day-to-day disciplinary aspects operating within the parent-child relationship are appropriated and augmented by the nurse in the interests of the nurse-client relationship. Disciplining the child becomes a matter facilitating the professional encounter while at the same time, becoming insinuated into day-to-day discipline of the child by the parent.

In contrast to the skilled relay of discipline through mother Ann to toddler Mark, the example from the home visit illustrates a different potential for discipline. Helen demonstrates a lack of resources to get mother Paula to be disciplined in her treatment of the baby following a 'feed'. Operating within her own life-world, the mother's position of 'authority' over which aspects of instruction to follow-up on are expressed---displacing the nurse's typical position as expert in clinic encounters.

3.5 Enrolling members in a new institution

Based on examples of practice drawn from a variety of locales the claim has been advanced, following Giddens (1984), that these locales, as practice "regions", constitute practice in particular ways. It has been argued that members make 'readings' of practice regions demonstrating competence as they pick up cues regarding 'when to talk' and 'what to talk'. By engaging in competent practice, members' conduct is, however, also constrained. Not just any sort of talk is permitted. For instance, when Marcia responded by attempting to re-enter the counselling phase, after Helen's cues indicated that the counselling session had terminated, Helen was compelled to formally terminate the encounter by walking out of the office. Marcia's demonstrated 'incompetence' in knowing

'when to stop talking' had some bearing, I would argue, on Helen's formulation of Marcia as untrustworthy.

Marcia's 'experience' of the clinic is constrained by the rules of competence employed by nurses which suggest that only the child who has been brought to the clinic for immunization is a legitimate 'topic' for talk, and that once the immunization of that child has been completed the visit is terminated. At the same time, these 'rules' facilitate Helen's version of practice in addition to providing valuable information to her at a largely unacknowledged level (practical consciousness) regarding the 'trustworthiness' of clients.

The 'presence' of rules that constrain as well as facilitate work are 'observable' in practice. By virtue of these rules, knowing about them and how they work in practice, actors are enabled to grow in size (cf. Latour, 1986). The knowledgeable enactment of practice gives the appearance that, in the clinic setting, nurses *hold* more power than clients in the clinic as well as more power than they do in a home visit. That is, in the immunization clinic, Helen, as a relatively big actor, has the power to walk out of the clinic office when she believes the session is over.

This appearance could be attributed to 'context'. The clinic as the nurse's domain might be said to give the nurse's the power to act decisively. However, this would be to reify the institution of the clinic as a work domain. Such reification has been rejected with reference to Lyotard (1979/1984) who describes it as "too unwieldy". Instead, following Latour (1986), power is understood not as something which is held by some individuals and not by others but rather reflects the outcome of a process of 'enrolment'. That nurses' appear to be more powerful in the clinic is more fruitfully examined in terms of the result of clients being enroled in particular ways so that power as an effect is produced. The fore-going discussion regarding the parent's pre-disposition to 'fracture' their own life-worlds upon entering the clinic stands as an example of an important condition facilitating the nurses' ability to enrol parents into work at the clinic.

Previous examples have demonstrated that the nurse's position as 'authority' in the clinic, while widely observed, is not entirely beyond question. For instance, Ann's laughter in response to Helen's suggestion that Ann's baby

should be fed more in order that his weight percentile could catch up to the height percentile had the effect of suddenly deflating Helen's 'size' as a clinic actor. Ann 'saves' the graphed measurements (after all she is enroled) by pointing to her older child as an exemplar of disproportionate measurements, but Helen's ability to issue instructions is drastically altered. She can only suggest that "sometimes that length will parallel off".

The point to be made is that 'reified' notions of institutions as reservoirs of power from which selected members draw in order to act are inadequate to explain conduct at Hillcrest Clinic. In the following section, I will argue instead that conduct at the clinic is illustrative of a 'networking' of interests; interests which contribute in particular ways to the constitution of the particular form of practice as it has been excavated in this study.

4.0 A network of 'interests'

The form of practice depicted in the preceding chapters suggests a rupture and a turn away from previous formulations of community health nursing reported in the literature (Stewart, et al., 1985; Turton & Orr, 1985; Littlewood, 1987). Rather than the nurse seeking out problems in the community, nurses at Hillcrest Clinic demonstrate a preference for a practice relationship located in the clinic. Clients come to the clinic at specified intervals and it is around these historical moments that the form of practice is organized.

The shift in practice 'locales' has been accompanied by a shift in the privileged 'site' for surveillance, that of auditing parental accounts. Practice has moved away from its previous location in the home environment, that is, within the parent's life-world, to its present 'dis-location' in this new setting. The effect of this gradual shift has been that nurses have instituted a new institution: the community clinic.

I employ 'institution' in Lyotard's sense where an institution is understood as a set of regularized practices informed by supplementary constraints marking the admissibility of statements. This supports the view of practice excavated in this thesis where nurses and clients are understood to encounter one another in regionalized spaces which inform members not only

when to talk but also what to talk. In the following sections I will explore the conditions or supplementary constraints which contribute, support and facilitate this new, institutionalized enactment of community nursing.

Conduct in the clinic is understood to be networked, that is, interdependent with those conditions contributing to its constitution in the present form. To the extent that nurses' conduct is 'networked', it is anticipated that any attempt on the part of clinic members to alter their practice will cause members to make some account of these conditions. For instance, during the fieldwork a nursing model was being introduced as a system for standardizing the records of nurse-client encounters. Clinic members stated the model was expected to assist them in the identification and management of client 'problems'. As a new language available for accounting for practice, it is expected that implementation of this nursing model would be accommodated as it comes 'up against' the supplementary constraints presently informing institutions of practice at Hillcrest Clinic.

Drawing on 'accounts' from client and staff members, I will illustrate how supplementary constraints facilitating the shift in practice locales to the clinic setting are 'present'. I will also explore members responses to the 'presence' of these conditions which, as has been stated earlier, are understood not only to constrain but also to enable forms of practice at Hillcrest Clinic. Networks not only facilitate practice at the clinic but at the same time provide materials for members to account for that practice. In this way, practice is said to be recursively constituted through interaction.

4.1 Government interests

Services offered at Hillcrest Clinic are funded by the provincial government. During interviews with clinic workers, the funding agency's influence on practice generated a considerable amount of talk amongst nurses and managers. Nurses claimed that they were being asked to be 'more accountable' for their practice. In order to address this question of accountability, a nursing model was being introduced into day-to-day practice in this setting.

The nurses understanding of the nursing model underlined the implications they expected the model would have on their day-to-day practice. For instance, nurse Diane 'accounts' for the introduction of the nursing model both in terms of the rationale advertised by clinic managers as well as its' anticipated benefit in her day-to-day work:

> Diane: (...) what they're telling us is that ... they ... in order to get money from the government you know for public health, we have to *show* that we're doing, we have to prove that we're doing a certain amount of this or that or ... and they think this will ... sort of solidify our work maybe, or at least show ... well I don't know exactly how they're going to use it but I think they want a more organized way of writing things down.

Although unclear as to "exactly how they're going to use it", Diane suggests that the nursing model is going to "organize" the way in which practice is "written". The advertised goal of the model is to "show" work. Only work demonstrable in the terminology supported by the model might be expected to be funded. It is important to note that the model is being introduced, not in response to an expressed 'need' to practice in a better, more "organized" way, but rather, to "show" practice to the funding agency.

The model's benefit of facilitating staff members' ability to "show" practice, also position staff to account for the model's presence in the clinic, now on a post hoc basis. The model legitimates particular forms of practice. For instance, nurse Kay suggested some of the 'benefits' of using this model:

> Kay: I think hopefully we've learned to be a bit more astute about doing assessing, doing proper client assessments. The tools that we've used to assess have been good ... **(sighs)** but now we're getting into Orem's self-deficit theory of nursing and the aspect of contracting with clients and ... and trying to bring them along to a point where they'll be able to recognize for themselves what they'll need to do. All that kind of thing and hopefully that tool will help us in finding out where their health deficits are **(laughs)** if that's the terminology and uh ... educating them a little bit about them.

Even though the model had not yet been formally introduced into work practice, Kay indicates that she has already 'worked out' an account of the model, accommodating the 'benefits' in terms of day-to-day conduct. The model,

introduced to secure government funding, has now been turned around, post hoc, and is being accounted for by Kay as a technology, an 'improvement' over previous "tools" used to assess clients. The crucial 'move' legitimated by using Orem's model is that it is said by Kay to assist clients to "recognize for themselves what they'll need to do". The 'interests' of the government to hold agencies accountable for finances , is 'networked' with the nurse's interest of enacting particular forms of health promotion, forms which, rhetorically position the client as 'responsible' for changing his or her behaviour. Kay's interest in providing 'client-directed' care rather than 'nurse-directed' care is facilitated through the 'presence' of the model in clinic discourse.

It is because practices at the clinic are networked that such post hoc accounting is possible. Giving critical attention to post hoc accounts raises the possibility of considering the attribution of 'economic' or 'technical' benefits to the nursing model as 'social moves'. The government's 'economic' account for the model and Kay and Diane's 'technical' account of the model mask the skilful deployment of *social* mechanisms in the production of accounts underpinned by rational, economic or practical *interests*. These accounts only *appear* to be independent of other interests involved in the production of practice excavated in this thesis.

The danger in not questioning the basis of these accounts as 'post hoc reasons' for change is that the social may be effaced "only in ways that erase the ethical" (Munro, 1993). The concern in this thesis is to illuminate the social in order that the impact of practice can be investigated as resulting from a series of 'moves' with demonstrable effects for members engaged in health promotion encounters. Taking a critical attitude toward accounts, it is possible to recognize that the introduction of a nursing model facilitating surveillance over practice by a funding agency at the same time introduces a structure available for members to use in other ways. So, as Kay and Diane suggest, the 'presence' of the nursing model can also be drawn on post hoc to legitimate practices which, in all likelihood, pre-exist the introduction of the model. Now these practices have 'new' meanings; meanings which shift as a result of the availability of new forms for accounting. With the introduction of the nursing model, taken-for-granted

understandings of practice are now re-invented as 'techniques' for getting clients to "recognize for themselves what they'll need to do". Such an account effaces the nurse's presence in the encounter and ignores the influence of power on client understandings. By attending to the post hoc accounts of members as illustrated above, moves can be explored as effects of powerful networks of actors enroled in the business of 'processing' clients through an ostensibly 'free service'.

This point can be illustrated further with reference to a study undertaken in the U.K. and reported by Goodwin (1987) in which she described health visiting caseloads as "simply too large to allow [health visitors] to give a service which they feel is of adequate quantity and quality" (p. 101). Goodwin's 'account' of health visiting work represents a material 'fact' which might be enroled by funding agencies to legitimate an economic move towards a model of practice more in line with that illustrated in this study.

Compared with the traditional model of a series of visits to 'new' mothers over the first five years of a child's life, as is presently the norm of British health visitors, Hillcrest represents an 'economic' version of community care. Valuable time spent by nurses travelling from home to home is 'saved' by having parents attend a clinic offering centralized services. If the home visit observed during the fieldwork can be considered 'typical', then the one and a half hours spent by Helen with Paula is 'costly' indeed when compared with a twenty minute clinic 'counselling' session. It is important however, not to take the notion of 'economic' too narrowly.

The rupture and turn away from more traditional forms of enacting community nursing as illustrated by conduct at Hillcrest Clinic is representative of what Foucault takes to be the essential issue in establishing the "art of government" (1978/1991, p. 92). Conduct in the clinic involves members of the community coming to the clinic, largely positioning themselves for the encounter with the nurse. Once there, nurses apply technological devices to the child's body to make children the 'same' for the purposes of the nurse's work, that is, the child becomes 'predictable' for the nurse, records can be made, statistics held. The swiftness and impact of this transformation of the child has been demonstrated to be mitigated considerably in the home visit. The shift in

the 'site' of action to the clinic produces a more effective (that is, 'economic') social displacement when parents are brought out of their homes.

This is the crucial move: the effect of institutionalizing community nursing in the clinic is to make families the instrument in the government of populations. It is this particular series of events which Foucault takes as the necessary conditions for the emergence of an art of government. With the birth of the concept of 'population', 'family' ceases to be the model for government and becomes, instead, the "privileged instrument for the government of the population" (Foucault, 1978/1991, p. 100). Budgetary interests become enrolled for the purposes of 'governing' populations.

The influence of government sponsorship cannot be discounted when studying shifts in conduct such as those taking place at Hillcrest clinic. The implications of the shifts demonstrated as a preference for practice conducted in the clinic will be missed unless the social is fore-grounded in analytic accounts. For instance, consider the organizational 'fall out' entailed by moving the nursing assistant to secretarial duties as discussed in chapter eight [p 230]. Economic 'considerations' mask the social implications where forms of representation are at stake.

Within a society defined by conditions of late modernity, that is, by practices deeply embedded with modes of surveillance and discipline, conduct in the clinic cannot be divorced from the conduct and accounts available from managers and funding agencies. Drawing on available structures, they may draw through different meanings but use the same mechanisms as nurses to monitor and discipline the practice of community health nursing as it is conducted at Hillcrest Clinic. An emphasis on practice conducted in a central location, thus 'rationalizing' the services of 'expert practitioners', is understood as not only serving the interests of those concerned with rising costs of health care funding. The issue is much wider than this. As the foregoing discussion of governmentality underlines, these 'accounts' attempt to mask or efface the power relations governing social displacements effected through the employment of families as instruments of practice.

4.2 Client interests

Working in tandem with the clinic services offered by nurses and funded by the provincial government is a 'response' on the part of clients, that of wanting to take up what is considered a 'free' service. For instance, during an interview with mother Glena, she gave the following account regarding her feelings at being treated differently than her friends by clinic nurses:

> Glena: The only thing that they did differently with me was that they didn't come for a home visit because **(laughs)** they decided that I didn't need one which ...
>
> MEP: Oh?
>
> Glena: ... is probably true but I kind of felt left out on that one because everyone else had a home visit except me, not that they did anything differently with them I guess ...
>
> MEP: They didn't ask you about that, they just, did they phone up and tell you that?
>
> Glena: They phoned up and said they couldn't get a hold of me for a few days **(laughs)** and I said it is because I have been out every day and they said well it doesn't sound like you need us then. And I said no, I guess I am doing alright and they said just come in if you want to get her weighed so I went in and had her weighed, but that was about it and pick up some pamphlets. And I guess that is all they do on home visits any ways so (...) I am not too sure what they do because I have talked to a lot of girls and they said that it is really nothing but ... it was, I was still a first mom so I thought, I thought, I kind of felt left out that way a little bit.

Glena describes feeling "left out" because she did not receive the same services from clinic nurses as her friends had. Glena dismisses this "difference" by suggesting that the home visit was not deemed by her friends to be crucial: "not that they did anything differently with them I guess ... ". Glena did take advantage of the 'free' service of coming to the clinic to have her baby weighed. There, Glena also received pamphlets. In terms of material gain, these activities put her back in line with her friends who had the home visit. However, Glena is unable to let go of the underlying point that she was, after all, a "first time mom" and felt "left out" by not having had the home visit. For Glena, contact with clinic personnel represents an 'opportunity' not to be missed.

As a representation of the practice conducted by clinic nurses, such an account reflects widely held understandings by parents in this study of contact with clinic nurses. 'Conversation' as a strategy-in-use by clinic nurses plays a part in enrolling parents into the operations of the clinic by presenting it as a friendly place. A parent's impression that clinic staff "wanted" to be there, that for them immunization clinics are treated as a pleasurable activity defying typical definitions of 'work', are, I would argue, influenced to a considerable extent by the friendly manner in which these contacts are organized by the nurses. A free but onerous service might be one which parents would not be compelled to return to. If the trip to the clinic required too much 'work' for the parent, they may not come back at the scheduled times. The reciprocality is underlined by the fact that parents are undoubtedly aware of the instrumentality of the questions asked. However, as has been argued above, parents have 'positioned' themselves for the clinic visit. Thus, the instrumentality can be largely displaced through pointing to what they get out of the visit (confirmation of child's development, reassurance that they are doing a 'good job').

In chapter eight I argued that an underlying function of the clinic visit was to alert parents to 'expert' versions of development so that the surveillance function could be turned over to the parent [p. 250]. This form of practice has a direct impact on the development of asymmetrical relations in the clinic. Additionally it was demonstrated to be effective in accomplishing fractures in the life-world of the parent's home setting. These extensive effects are not accounted for in parent's reports of friendly clinic encounters. I would argue that the effects of the encounter are mitigated by enacting practice through the strategic deployment of 'conversation'.

In chapter seven, I suggested that the representation of the child constituted by clinic personnel, a representation obtained as a result of applying measurement devices in particular ways onto the child's body, had the effect of displacing alternate versions which the parent might apply to their child [p. 211]. In that chapter I suggested that the nurse's version might be regarded as a technical, quantified representation while the parent's would be a qualitative representation of the child. I would revise that distinction which, in light of

discussions regarding the readiness of parents to fracture their life-world, might have been premature.

I will continue to hold the view for the present time that the parent's representation of the child is significantly *different* from that of the nurse. However, that difference may take only an alternate technical form. The parent's version of the child's body is deferred, by the parent themselves, as part of the fracturing of the life-world. The process of fracture is, I would argue, a condition making access to the clinic possible for parents. 'Making access to the clinic' should be understood as the networking of parental interests with those of the clinic including those of the government sponsors.

My point is that, to some considerable extent, parents leave their life-world at the door of the clinic in order to 'capitalize' on the technical services offered by clinic staff. When wife Susan turns to husband Paul to relay the nurse's disciplining move regarding the height of the Jolly Jumper, Susan signals the extent to which she has already fractured her life-world in order to take up the nurse's instruction. She is "pre-disposed" (Munro, 1992) to the instruction. This pre-disposal rests on her complicit conduct of fracturing her own home life-world, to view *that* world as technical in order to 'capitalize' on the nurse's discipline. The spectacle of Jane in the Jolly Jumper was already a technical event. Susan reported that they were "both sitting right there", watching the child 'develop'. As a result of the trip to the clinic their already technical perspective has been more finely honed. The Jolly Jumper will never be the same as both parents now monitor Jane's "toes" and "heels" at least until she turns six months of age. Even then, as Susan remarked in her interview later, they will continue be on guard for all the other things which could occur in the course of Jane's lifetime. Describing Jane's reaction to the immunization Susan recounts:

> Susan: I was by myself as a matter of fact that weekend so that was kind of a nightmare. Actually it wasn't too bad. She was just cranky. Yeah, but that was mild, that was nothing compared to what could probably happen in her lifetime.

The visit to the clinic offers parents the 'security' of confirmation. The health 'experts' confirm what parents already 'know'---that their child is healthy. The visit provides parents with additional (technical) discursive spaces enabling parents to make 'competent' accounts of their child's development. The discursive space available to parents by capitalizing on clinic services can be deployed in any number of circumstances to counter or support 'competing messages' from family members, self-help guides, physicians, and friends.

The fore-going interpretation of contact between client and nurse is vastly different from that portrayed in Bloor and McIntosh's (1990) study of Glasgow health visitors. There, the home visit was described by clients in terms of an 'invasion' by the health visitor. The difference is marked most clearly by Glena's feeling of being 'left out' and results from very different conditions constituting practice at Hillcrest clinic.

I am not suggesting that nurses at the clinic have 'calculated' the effectiveness of 'conversation' on the particular mode of practice enacted in day-to-day encounters. More, as I will elaborate in the following section, 'conversation' represents a strategy-in-use in the clinic; a strategy staff members have 'worked out' over time as an 'efficient', and 'economic' (*vis à vis* effecting governmentality) way of conducting their work. Using conversation in encounters with parents 'pays off' dividends for nurses. That it has other, wider effects is a matter which I will take up now.

4.3 Nurses' interests

Foremost in a discussion regarding modes of practice enacted by clinic nurses is the issue of 'space'. Nurses constitute their conduct in the clinic as 'non-invasive'. 'Health' is accounted for by these nurses as a concept firmly in the client's domain. Nurses give discursive accounts of sanctions against 'persuading' clients to take one particular view over another. Nurses talk about 'knowing' when to "back off". In the Senior's clinic, 'help' is constructed as providing information so that senior residents in the community can approach their own physicians from an 'informed' position. Yet the nurse takes the view that it is important for the client to approach the physician themselves,

concerned that she may exert undue 'influence' over the client-physician relationship.

These discursive accounts of practical 'sanctions' on conduct are linked with a particular position toward 'the other'. The point I want to underline in this section is that these accounts stand in contrast to the effects of disciplined and disciplining practice enacted by nurses and illustrated in the preceding analysis.

So how can this apparent contradiction be reconciled? As suggested earlier, these discursive accounts will be examined as they reflect post hoc accounts legitimating action by referring to the technical or the practical but in so doing possibly effacing the social (but not erasing it, for they do have demonstrable and reportable effects). For instance, while nurses suggest that using Orem's model facilitates a form of 'objective' practice, that is, practice in which distance between nurse and client can be accounted for as a necessary, technical element to ensure client independence, in fact such distance has been demonstrated, with reference to moves and displacement, to be impossible to accomplish in practice and, in any case is wholly undesirable in a practice-based discipline such as nursing.

When Helen describes her 'plan' for her encounter with Paula, she is informed by a variety of materials available to her, for instance, "referrals" produced by other health care worker's from their contacts with Paula when she was hospitalized for the delivery of her baby, as well as records relayed to Helen from the clinic where Paula had her older daughter immunized. In practice, Helen claims to take an 'open' approach to her work, showing all written materials used in the encounter to the parent. However, in Paula's case this open approach was altered:

> Helen: There was a question on the referral on whether or not Mom was on her own or whether Dad was on the scene and all this kind of stuff. Well I never bring those kind of referrals because I show all the paper work to them, I wouldn't bring something like that that has somebody else's subjective evaluation on them, because I wouldn't want them to get their back up and get them defensive against me.

Helen's account suggests that by displaying the paper work to the client, her work is facilitated because the client sees the paper work not as something 'secret' but merely an 'objective' (visible) report of the responses given by the mother. In this case however, Helen did not bring the referral sheet to the home visit because she did not want Paula to see "somebody else's subjective evaluation". Helen suggests that such "evaluations" may have deleterious effects on the developing relationship between nurse and client. If Paula were to see the 'subjective evaluation' she may become "defensive" toward Helen. In order for Helen to accomplish her work, it is important that such defensive responses are deferred, even if that means not showing "all the paper work" to the client.

All staff members acknowledged a concern with the issue that their work involved a significant amount of 'subjective judgement'. Within the scientific discourse which has played such a significant part in constituting understandings of both nursing research and practice over the past forty years, 'subjectivity' is treated by nurses in the clinic as something to be eradicated from their work. Adoption of a nursing model was 'present' for members to draw on in order to portray their work with clients as more objective:

> Diane: When you look at some of the really good charting that is done using that process or any kind of framework of nursing that ... reading the charting there's a very little judgemental statements in there, which are really nice. I think some of the charting that you see is just ... you know or somebody writing on their gut feelings about things ... mother is doing this or mother ... it's just a judgment, an opinion. I don't think that's very appropriate thing to be writing down.

Diane suggests that "any kind of framework of nursing" would have the desired effect of eliminating or at least reducing the influence of subjectivity in practice. The effect sought after are ways of accounting for practice which can be recorded with "very little judgemental statements", considered by Diane to be "inappropriate" as written records of practice.

These accounts efface the social. Only by making the readings available in the regionalized clinic spaces or being displaced in the client's home does the nurse' know' and, on the basis of that 'knowledge', act. The readings underpinning what are referred to as "subjective" judgements, are, I would

argue, 'masked' by accounting for practice as an 'objective' endeavour. Nurses at Hillcrest Clinic have formulated a version of practice reflecting a certain position towards the 'objective' world. That is, in shifting away from visual surveillance in favour of an audit composed of cross-checks on reportable conduct, nurses are operating on an understanding of 'observations' as either an untrustworthy representation of reality or, that making an observation involves making a 'judgment' on the part of the nurse. As Fran noted during an interview, as "biases", judgements are 'problematic' for nurses:

> Fran: I guess it is a bias to say that they're well dressed and but you can't help those, I mean you can't help those biases. I mean, you know if the baby were dirty and had a diaper rash, you know, things like that. And usually it's not just single things, it's usually a few things.

Fran suggests that she does not rely only on one sign but must see "a few things" to cause her to make a 'judgement' about parents.

As an alternative to observing, 'listening' is treated, and I would suggest, taken-for-granted, as a more 'reliable' way of obtaining information about 'others'. 'Listening' to parental accounts of childhood development and parental responsibilities for this development, the shift in 'sites' for work from the visual to the aural / oral finds a more 'secure' basis. Nurses can now allow observable signs to influence them. As Fran says, "you can't help those biases". However, by attending to parental concerns, reflecting those concerns back to parents (disciplining the parents) in the form of 'expert advice', taking account of the competing messages parents are "up against", staff members constitute their work as a less adulterated version than practice which relies solely on observation.

The service at the clinic is 'technologized' through the use of graphs and measuring devices, eye tests, balance tests, and the advertisement of 'clinic policy'. As a step removed from individual judgment, policy offers another amelioration of the 'problem' of judgement and invasion of personal space. Diane tells the mother that if she 'chooses' to give her child fluoride, clinic policy states that it is "more effective if given with water". Coming at the end of a sequence where mother Molly had made several attempts to defer the advice,

Diane's move to distance herself from this instruction with reference to clinic "policy" acts to dispose of the 'problem' of invading Molly's space. The 'moves' involved in accomplishing this type of instruction point to a strategic use of 'conversation'. 'Conversation' is not only to keep the encounter between the nurse and client 'light', to facilitate the rapid movement between topic areas, but also, to punctuate instructions, the crux of the nurse's work in the centralized locale of the community clinic.

This shift in 'sites' from the visible to the preference for 'audit' develops beside and in tandem with the strategy of enacting 'conversation' to elicit accounts. Nurses have 'translated' scientific aspects of the assessment process into a more amenable form, that of conversation, making the life-world of the clinic a place where 'common sense' advice, "hands on sort of stuff" is available. Crucially this means that the clinic is also the place where 'moves' are possible.

'Community nursing practice' emerges as 'practices': there are no laws governing the relationship between client and nurse. Rather, privileging accounts given by parents, and in this way, placing the family in a privileged position, nurses use conversation as tactics or practices to generate material for work. Work involves having space to move around. The clinic, as a locale where parents are more efficiently disposed to provide accounts as a result of the obligating effects of the regionalization of space in that locale, arises as the centre for governmentality effects.

In the discourse of 'helping' in societies of the "late modern" age, it has become too difficult for nurse's to institute 'action' based on a 'judgement'. Nurses have accommodated this difficulty by moving their work to the clinic: a centralized, 'neutral' location. The clinic represents a location where differences among parents can be largely deferred. In the clinic, nurses offer a service, free of charge, to any member of the community. Clients attending the clinic are treated by nurses as having already 'positioned' themselves, that is, already fractured themselves from the life-world of the home, in order to partake of the service on offer. The effect of this fracturing of the client's own life-world ameliorates to a considerable extent the 'problem' posed by the nurse's work of invading the client's space.

5.0 Conversations and institutions

The discussion returns, in summary, to explore the 'networking' of interests framing modes of practice at Hillcrest Clinic in light of Lyotard's observations on language games. Lyotard makes an important distinction between "an institution" and "a conversation". In conversation

> the interlocutors use any available ammunition, changing games from one utterance to the next: questions, requests, assertions, and narratives are launched pell-mell into battle. The war is not without rules, but the rules allow and encourage the greatest possible flexibility of utterance (Lyotard, 1984, p. 17).

The analysis of social conduct in the clinic has demonstrated that parents and nurses enact practice in a form which suggests that they know '*when* to talk' (an effect which might be explained away in some studies as peripheral, as merely demonstrating a 'common' social competence) and also that they know '*what* to talk'. This latter observation is less easy to dispense with, although I would argue that the first observation, that of social competence, has received inadequate attention within the nursing literature and stands as equally as significant a finding as the second. Lyotard's description of 'conversation', as demonstrated through "flexibility" of utterances stands in distinction from the highly regularized interactions observed in the clinic. The finding of interactional 'regularities' such as demonstrations of knowing when and what to talk might be described as 'institutional talk'.

For Lyotard, in contrast to conversation, talk in institutions

> always requires supplementary constraints for statements to be declared admissible within its bounds (Lyotard, 1976/1984, p. 17).

The effect of the constraints to which Lyotard refers, I would suggest, is to give definition to the institution within which talk takes place. In this chapter I have argued that these constraints represent the very conditions upon which aspects of clinic work are made manifest. Supplementary constraints offer language partners parameters within which to operate. This is consistent with Giddens' view of structural constraints where the duality perspective reminds us that structures which constrain also enable. It is also consistent with Foucault's

claims regarding the conditions enabling "clinical experience to become possible as a form of knowledge" (1963/1973, p. 196).

Institutional conditions which make practice decisions possible, that is, the staff's situated understanding of the relation between "help and knowledge" (Foucault, 1963/1973, p. 196) are the same conditions which enable but also constrain possibilities for action within the clinic visit. For instance, whereas previously the child's body was 'available' for surveillance, this availability was not understood as 'helpful' by staff members (the effect of a particular gaze), and so, the availability is surrendered in favour of 'saving time' for counselling. As Lyotard suggests,

> the constraints function to filter discursive potentials, interrupting possible connections in the communication networks: there are things that should not be said. They also privilege certain classes of statements (sometimes only one) whose predominance characterizes the discourse of the particular institution: there are things that should be said, and there are ways of saying them (Lyotard, 1976/1984, p. 17).

The rules of the institution of immunization clinic talk act to condition talk in the clinic. Crucially, this view of institutional talk concerns itself not with prescribing ways of avoiding the constraints of institutions but rather with acknowledging their existence and questioning the effects they have in particular settings. The possibility is raised for understanding 'conversation' as it is employed by nurses at Hillcrest Clinic, as a technology, an instrument, which plays a crucial part in defining the institutional aspects of talk in the clinic.

The effect of shifting out of conversation and into a highly technical and regulated form of instruction is to highlight, to punctuate, the instruction. This effect can be understood as having implications on the parent's ability to fracture their life-world. The shifting from conversation to instruction acts as an 'alert' to parents that an instruction is imminent; they can position themselves for it.

The 'presence' of organizational structures such as nursing models and policies serve to distinguish 'the technical' from 'the conversational' at Hillcrest Clinic. However, the effect of institutional talk is in no way mitigated whether the nurse is in conversational mode or in technical mode. Thus, I would argue, that at Hillcrest Clinic, the nurse's conduct suggests that they 'know' at some

level, that is, they have 'worked out' the advantage to marking distinctions between conversation and instruction because it *'works'*. The nurses' demonstrate an acute knowledgeability that the strategic deployment of 'conversation' and 'instruction' facilitates particular action in the clinic. This knowledgeability is implicated in the viability of interests in their practice.

In this chapter I have explored one particular encounter observed during the field work which demonstrated how nurses at this clinic are enabled, through institutional constraints to define problems and to suggest remedies to these problems, all from the centralized location of the clinic. The surveillance enacted by Helen over Marcia was not one of interrogation. She did not wait for Marcia's account of Kim's inadequate weight gain. Instead, it was Helen who provided the range of accounts. Such conduct points to the generation of talk about possible realities rather than definitive realities as the object of nursing work. The production of accounts emerge as a surface upon which nurses find possibilities for 'breaking in' to instruct, thereby disciplining the parent's understanding of their child.

The networking of interests of funding agencies, clients and nurses have been explored to suggest some of the conditions which are operating to facilitate practices conducted by nurses in this setting. Nurses at Hillcrest Clinic, in conjunction with prevailing conditions in a late modern society which draw client interests and government interests together with the nurse's own professional interests, enact a form of practice which has centralized the knowledge function. That is, in the clinic, where the parent comes with life-world already fractured, and the nurse's 'authorial' presence is at its most immanent, the conditions are "possible", as Foucault has argued, for help and knowledge, to "become necessary" (Foucault, 1963/1973, p. 196). Within the centralized locale of the clinic, nurses are positioned to displace or enrol parental versions of child development in order to show 'knowledge' and 'help' through instruction. The disciplinary effects are mitigated to some extent by conversational strategies but these, at the same time, serve to underline the very disciplinary nature of the institutional talk constituting 'health promotion' at Hillcrest Clinic. That is, the re-location of practices for conducting health

promotion takes account of the effects for nurses' conduct on differing levels of presence availability of the parent's life-world and thus influence the viability of interests framing practice in the clinic.

CHAPTER TEN

Reading Nurses' Practice

> The more consistently I deploy my strategy of survival, the more I am left alone. Loneliness is frightening and unbearable, because of my uncertainty as to how adequate are the weapons I deploy to fight off the threats to my body. The know-how as to what weapons to select, and the weapons themselves, I can obtain only from others -- from those who control the access to weapons and possess the knowledge of how to use them. Being alone makes me dependent on others. It opens me up to others, but in a particular way, leaving a profound imprint on the shape of ensuing sociality.
>
> Z. Bauman, Survival as Social Construct, (p. 20)

1.0 Excavating 'practices'

The thesis advances a *reading* of work activities observed in one practice locale. This reading of work activities suggests that the stated aim of providing health promotion was enrolled by community nurses to distinguish their services from those of other professional groups. The interpretation of work activities is based on critical methods. Interactions occurring between nurses and clients were transcribed and drawn on as the primary source for interpretation. Interpretations arising from transcribed interactions were cross-checked first with observational fieldnotes and secondly, with interviews conducted with nurses and clients after the clinic interactions.

The reading made of clinic activities illustrates that practice at the clinic has been conditioned by the 'intrusion' of a discourse of health promotion. For instance, the friendly atmosphere of the clinic suggests that nurses 'know' they must provide a 'client-centred' service and not one modelled on more traditional images of the knowledgeable nurse 'telling' patients how to behave.

The remnants of this more traditional form of work remain; they have not been eliminated, but have become effaced by mentions of 'policy' or 'research'. For instance, when mother Paula questioned specialist advice she had had to begin feeding her three week old child solid foods, nurse Helen supplemented Paula's comment that the advice was incorrect with official clinic policy. When Paula indicated that she planned to hold off giving solids until the baby was six months of age, Helen's support came in the form of "that's what we push for" [p. 173]. Clinic workers mediate advice through institutional circuits, effacing discipline with references to collective 'knowledge'.

While nurses have eschewed traditional, one-way communication models characteristic of principles underpinning early health education, practice, as illustrated in the thesis, does not evidence a turn to an alternative, unified model of practice. This is not to suggest that practice is without 'order'. Given the relative isolation in which nurses practice in this locale, their conduct of 'counselling' is perhaps surprisingly consistent. For instance, all nurses, except for Fran, a recent recruit, used measurements taken out in the waiting room as a 'way in' to counselling [p. 210]. Despite claims to individual differences, for instance, Helen's strategy for not leaving the encounter open right off the bat [p. 161], strategies for conducting counselling sessions were not observed to have demonstrably different effects. The organization of practice is manifest in its enactment, yet it is has no 'obvious' source. To reiterate once more, specific actions demonstrate *order* --yet action is not pre-determined. The aim of this study has been to excavate this order; not to make the move towards generalization and the ensuing fall into functionalism [p. 62]. Rather, the aim has been to facilitate a shift in attention towards the specifics of conduct, a shift which demonstrates how it is that the specifics constitute 'order' not that an external order *causes* particular actions.

The 'order' of practice observed in the clinic could not, for instance, be attributed to the 'presence' of a nursing model. In this respect, these nurses are similar to Benner's nurses. Apparently operating on theories grounded in the practice setting, the nurses' conduct was not driven by any one formal theoretical framework. Instead, nurses in the clinic have worked out 'efficient' ways of conducting their work. The twenty minute time slots provide them with the competitive edge over more technically advanced professional groups. Within the time frame allotted, nurses give friendly, practical advice on 'how to' parent -- their own form of 'specialization'. There are few 'checks' on this provision of service.

Managers make spot-checks on client satisfaction levels but these do not appear to influence the nurse's conduct, merely providing opportunities to reproduce accounts recursively constituting forms of practice already enacted at the clinic [p. 246].

During interviews nurses did make reference to the in-coming Orem model. Opinion was divided here. Some nurses enrolled the model as a way of facilitating the move to 'specialized' practice. Others, more sceptical, accounted for the model as merely a "different way of writing" what they were already doing in practice [p. 277]. Scepticism may arise from a knowledgeability informing these nurses that 'writing work differently' may have significant implications for modes of accountability on their work. Writing work differently may make aspects of work which were previously 'invisible', available and therefore subject to account by nurses. Again, the extent to which much of the work was 'invisible' in this way, that is, accountable, makes observations of sustained conduct more interesting. Sustained conduct is not being driven by formal modes of accounting for work.

At the time of the observations of practice reported here, much of the work accomplished by nurses was relatively 'invisible' to management surveillance. Indeed, the nursing manager planned, during her up-coming two year educational leave, to investigate evaluation methods for managers of community nursing services. The manager was aware of constraints within which she operated regarding her ability to 'manage' day-to-day nursing activities at the clinic, with all that entails. The manager attributed these constraints with the 'fact' that much of the nurses' work was conducted behind closed doors or out in the community. Again, the absence of a formal model for nursing practice against which day-to-day practice could be measured is underlined.

Despite the absence of formal structures for calling nurses to account for their work, the image of work manifested at this clinic represents organized, collective action which has apparently evolved in circumstances where work is conducted in relative isolation. I have rejected Benner's thesis that such forms of collective action might be explained by attributing individual nurses with vast amounts of experience, accrued over time, which can be accessed by the

researcher through *accounts* of practice alone. The explanation offered here goes further than Benner's. The reading of work offered here draws from representations of practice in the form of transcribed encounters, cross-checked against observations of practice and interview accounts of practice. The reading of work activities advanced in the preceding chapters illustrates that these nurses do operate within particular and advanced frames of knowledge. But the interesting feature of this work is that the knowledge is not directed toward the subject in the form of a 'gaze'; it is apparently much more haphazard. The client's life-world *is* important to the nurse, that is, she relies on the obligating function of her actions to compel parents into making accounts. This may well mark the most prominent location of intrusion by the health promotion discourse on nursing practice. But parental accounts are abstracted by nurses in the narrowest of senses -- attention is paid to the account only to the extent that aspects of the account become available for appropriation by the nurse.

Such an account of practice stands against an understanding of health promotion as a 'gaze', in the sense which Foucault has given that concept (1963/1973). Health promotion as objective knowledge, available for application, for 'knowing' in systematic ways, is not yet available to be drawn on by these nurses to constitute a new identity as anticipated by the literature. Instead, health promotion is used as a facility for engaging in particular forms of practice which are, in their own way, connected to pathways of power contributing to the evolution of practice as expressed in day-to-day action in the clinic. The major themes arising from the reading of practice will be advanced next.

1.1 Territory of concern: inversions of the home

In the study, community nurses were observed to be engaged in practices which marked their work as a rupture and a turn away from more traditional ways of enacting community nursing. Within the disputed grounds of promoting 'good parenting', nurses no longer operate within conditions which make direct instruction an 'easy' option for work. Nurses' accounts reflect traditional understandings of the home and those who live there as privileged locations for practice. However, work activities in the clinic illustrate that the

nurses' surveillance has shifted from the geographical space of the home to the discursive space of parental accounts. Nurses attend to parental accounts as a 'site' where communicative practices, in the form of conversational techniques, are employed to raise up reports of parenting conduct. From the parental reports of conduct, nurses appropriate particular aspects: now the nurse is equipped with materials enabling her to 'break in to instruct'.

Perhaps the most portentous aspect of the way in which practice at Hillcrest clinic is organized is in this particular territory of concern: the practical accomplishment of parenting. For it is in the parental home that the parent's authority to 'know' what is best for their offspring, it might be thought, would be at its most unassailable. And yet it is in the home that the nurse's health promoting efforts are most clearly directed and intended to have an effect. It is precisely this assumption, the home as a 'safe' place, which the form of health promotion enacted in the clinic questions. The effect of practice is to invert the image of the home as a place of safety and security into a place of danger and risk. Although practice is typically conducted in the clinic, that is, at a significant distance from the home, rather than ameliorating the nurse's influence in the home, her influence is emphasized. How this strengthening of the nurses' influence is accomplished 'out of the home' is now discussed.

Warnings issued by the nurse for a parent to 'be aware' that a child could soon grab the edge of the sofa and roll off, injuring herself in the process, has the effect for the parent of increasing all forms of surveillance over the child upon returning to the home from the clinic [p. 241]. The clinic, constituted as a site for obtaining 'knowledge' about preventing dangers in the home environment, inverts the relationship between the home and locations of safety. Rather than the home representing the epitome of security, it is constituted through the interaction as the source of constant danger. Parents, affected by "the ensuing sociality" (Bauman, 1992a, p. 20) of this inversion, institute relays of discipline [p. 254] from one parent to another, planning alterations in the home on the basis of warnings from the nurse.

The effect of the visit as represented in mothers' accounts contributes to a view of childhood development as something which is never complete. Nurses'

act to alert parents that there is 'more to come' [p. 241]. Development too is associated with 'danger' and 'risk' during interactions conducted at the clinic. The manner in which these dangers are constituted underlines the apparently haphazard approach to 'problem identification'. Nurses in the clinic, at present, lack the 'gaze' which would frame and inform 'knowledge' in the way Foucault suggests a 'gaze' should. Within the disputed grounds of 'good parenting' secure knowledge of the form he argues medical knowledge is structured by is not yet available to construct associations between nursing work and knowledge on offer in the clinic.

Lacking a 'gaze' however, does not make the nurse's actions any less effective; they are, as demonstrated in the preceding chapters, perhaps all too effective. Lacking a 'gaze' does not negatively influence nurses' abilities to perform as experts. What does change is that this expertise cannot be said to be based in forms of knowledge analogous to those understood by Foucault as a 'gaze'. So what is the basis of the nurses' expertise? Parents may not receive 'knowledge' of any particular sort from a clinic visit. However they do report receiving 'reassurance' that their child is healthy [p. 216] and that by implication, as parents, they were doing a 'good' job.

The expertise demonstrated by these nurses is not, as Benner would have it, that arising from having experienced so many encounters that the nurse 'knows' which child is healthy and which is not nor what is making the child healthy or not. It is instead an expertise which derives from the nurses' ability to position themselves in particular relations to parents. This will now be discussed.

1.2 Expertise and hierarchy

The intrusion of health promotion discourse into practice has affected the location in which nurses practice. Parents come to the clinic and give accounts to the nurse. Parents provide the materials which are enrolled by nurses to illustrate 'dangers' in the home. Health promotion, as it is enacted at Hillcrest Clinic, is not illustrative of a concept available as 'objective' knowledge to be claimed as the territory of one particular group of 'professionals'. The reading

made of work activities in this clinic refutes this presupposition which underpins much of the literature on the topic. Parents construct the clinic as a location to come for 'reassurance' regarding their abilities as parents. Such reassurances however, set up conditions whereby nurses can instruct parents regarding future dangers. 'Danger' is given articulation by the nurse who positions herself as the 'author' of the child's body. The relation between authoring the child's body and the articulation with danger will now be discussed.

Nurses organize the flow of clients through the clinic. The first stop on this journey is to measure the child. The nurse transforms the child's body and in so doing, becomes the 'author' of a version of the child which facilitates work during 'counselling'. The processing of children of all ages through the technology of measurement effectively diminishes differences amongst children. The nurse is afforded an opportunity to make 'expert' claims about a child's *potential* for development. The opportunity to instruct arises because the nurse, unlike the parent, 'has been here before' (Law, 1986, Latour, 1987): the measurements arise within the territory of the nurse. She applies them and interprets them. Through measurement, unique aspects of the child of which the nurse may be quite unfamiliar (and thus unable to interpret) are sliced away, leaving only the inscriptions of which the nurse is familiar. Once the child's body has been 'sized', regulatory features framed by the measurements are brought to bear in the form of instruction to ensure the child's proximity to the norm -- these norms are the markers of 'health' in the clinic. And the nurses are "experts in normality" (Foucault, 1975/1977, p. 228).

Parents are alerted to hierarchies framing encounters in the clinic as well as the nurses' place within the wider health care organization [p. 230]. Nurses at Hillcrest do not compete with other professionals primarily on 'technical' grounds. Instead, they have constituted a niche for themselves in which time, personal attention and practical advice are advertised as what is 'special' about the clinic [p. 230]. Reminders such as these offer parents modes of access to the nurses' expertise. Parents who take such access up, contribute in material ways to the construction of the nurse as expert. The point to be underlined here is that

nurses are not solely responsible for the effects accounted for by parents at follow up interviews, two weeks after the interaction. In chapter nine I provided some evidence of ways in which the nurses' interests are networked with government interests and parents interests to produce particular versions of 'practice'. These networks represent complex social accomplishments also. They too represent 'orders' of knowledge into which, crucially, nurses have tapped in order to set up conditions upon which the service offered at the clinic is easily 'translatable' to client interests. These are the grounds of their expertise.

Linking routine developmental screening with immunization regimes establishes the grounds upon which nurses can offer a health promotion service which is more advanced than mere prevention. Parents, even if they have no 'concerns' about their child will, at least, have their child immunized. Any other 'interesting' information transferred during the interaction represents a 'bonus' [p. 184]. Having come to the clinic for the service on offer, parents can be expected to work quite hard to appropriate something from the service--they were, after all, not coerced to come in.

Parents are therefore 'primed' for the encounter. At the 'site' when accounts are generated and where parents have crucially already fractured their life-world in order to attend the clinic, nurses enact their particular form of expertise. Nurses capitalize on the conditions to enact highly skilled practices. These practices, what they consist of and how they are knowledgeably deployed by nurses, will be discussed next.

1.3 Conversation: an 'unusual' feature of work

Having positioned themselves and having been positioned by parents as 'experts', nurses capitalize on the conditions of possibility for their work in the clinic. Parents from 'modern societies' approach the clinic in already fractured states. As discussed in chapter nine, this fracturing of the life-world is aided by parents leaving the 'home' for the 'clinic'. These conditions offer nurses grounds within which to conduct their work from the 'economic' location of the clinic. They conduct this work within a manufactured friendliness operating in the clinic. All members are complicit in this performance. But by calling it a

'performance' I do not wish to suggest that the 'friendliness' is not also to be understood as genuine. The performance represents the enactment of knowledgeable, strategic conduct in the clinic. Nurses are 'serious' about their work: for example, they evaluate transcripts of encounters as 'mirrors' of their work [p. 171]. It is just this sense of seriousness about their work which distinguishes their methods *as* strategic. Nurses demonstrate their skill by keeping encounters light [p. 184], avoiding dangers inherent in their disciplining work. Encounters are neither too intrusive, thus attending to the health promotion rhetoric, nor too overtly evaluative, thus encouraging parents to return. Part of the skill involved in the work undertaken is in making it new and this is accomplished by the strategic use of communicative practices. These practices are now explored.

In the particular way in which 'practice' at Hillcrest Clinic is undertaken, there is a considerable overlap of 'health care' services. Hips are 'checked' at the clinic but only two weeks previously or two days later will be 'checked' at the doctor's office [p. 230]. Eye tests can be done in the clinic, or amended to make a 'difference' to those just done in the school [p. 160]. To a considerable extent nurses are in competition with other health professionals for space in which to give their message. The competitive spirit is given expression in the reproduction of the notion of 'competing messages' [p. 172]. Parents are said to be "up against" contradictory messages about the 'best' way of caring for their child. Nurses at Hillcrest Clinic meet this competition by providing a 'different' service than any one else.

'Difference' at Hillcrest Clinic is marked by 'friendliness', 'practicality' and 'time'. Each parent is given twenty minutes of the nurse's time. Twenty minute visits are longer than what mothers claim to receive in a doctors office but not long enough to make the visit to the clinic onerous. Day-to-day 'concerns' are encouraged to be given voice. Nurses at the clinic are less concerned with demonstrating themselves as 'specialists' -- as has been illustrated, some questions are hived off to special "divisions" such as "Sexuality Division" [p. 164] or to the physician [p. 188 and p. 230] -- than they are with expressing their 'specialty', framed by the availability of practical advice. However, this practical

advice is already 'technical' as it is given based on representations of the child 'authored' by the nurse. Nurses, in this way, reinforce existing hierarchies while effacing the technical nature of their activities as 'practical, hands on advice' [p. 179].

These nurses have 'worked out' a skilled importation of conversational strategies. Conversation, as it is deployed in clinic encounters, accomplishes a space for nurses to work within; a space which is separate and distinct from the physician; a space from which they can generate materials with which to offer a service which is then picked up and read by consumers as one they are in 'need' of [p. 261]. Conversation represents a flexible 'instrument', used in a highly skilled manner by nurses for cross-checking on reportable parental conduct. This important feature of nursing work will be expanded upon.

Conversation is used by nurses to bring the client's life-world into the clinic. But it is brought in in a particular way. That is, the client's everyday life-world is economically constrained by nurses to make it amenable, that is, appropriate, as a form of talk in the clinic. What children do may be explained by parents as things they enjoy, things they 'love' to do, but these are quickly packaged up in technical terms of 'grabbing' and 'rolling' by the nurse [p. 240]. Everyday conduct arising from the client's life-world is made 'present' to the nurse *in the clinic.* It is a transformed version of the life-world which becomes available for work through the nurses' obligating actions of calling parents to account. Conversation is used as a facility for generating accounts which are then cross-checked by nurses.

This skilled nursing performance can be contrasted to Foucault's reading of the physician's 'gaze'. Foucault, it will be recalled from chapter seven, used the concept of the 'gaze' to represent those forms of knowledge employed by physicians to construct a discipline of the body. Discipline framed what was visualized as the body and therefore what the body could inform the physician of. From the vantage point of the disciplined 'gaze', physicians examine bodies.

Nurses at Hillcrest have taken a quite different territory of concern. The body has already been colonized by medicine. This colonization contributes in significant ways to the conditions of possibility for nursing work. However, nurses at Hillcrest demonstrate considerable skill, drawing on the facility of

conversation, for making the home 'present' in the clinic. This presence is constituted primarily through audit. It is important to note that nurses work has incorporated a shift away from visiting the home, surveying it, evaluating it by *looking*. Instead, the nurse's primary way of knowing is through *audit*. Through audit, accounts are raised in particular ways, that is, economically and efficiently constrained yet also facilitated by the materiality of the clinic. Rather than knowing by looking, these nurses operate upon conditions which suggest they will 'know when they hear'. And what they hear are fractures in the client's life-world. Alert to fractures, nurses skilfully move in to mark these by 'breaking in to instruct'. Discipline is applied and the encounter moves on.

There is not a unified 'end point' to this activity. Rather, following Foucault on the 'ends of government', practices as they are enacted in this clinic represent action which takes as its end the management and pursuit of,

> the perfection and intensification of the processes which it directs; and the instruments of government, *instead of being laws*, now come to be *a range of multiform tactics* (1978/1991, p. 95, emphasis added).

A discourse of health promotion as it is implicated in the conduct of parenting lacks the definition from which 'rules' might emerge. Instead, nurses draw on health promotion as a facility which "intensifies" action in the clinic. Conversation offers nurses a facility for moving through topics arising from the everyday conduct of parenting and now transformed by time-space features operating in the clinic. Conduct is quickly and efficiently audited. Audit draws through fractures 'present' in parental accounts. Instruction, differentiated from conversation by "institutional constraints" (Lyotard, 1979/1984), disciplines parental actions and understandings. Such skilled action and the effects which can be traced emanating from it must be treated as a form of power. It is to a discussion of power, as it is understood to operate in the clinic, that draws the thesis to a conclusion.

1.4 The accomplishment of practice as an exercise of power

Within a tightly networked social encounter as theorized in the previous three sections are materials for exercising considerable power. The reading of work activities underlines the importance of examining not only those locations

where nurses and clients are physically present with one another in encounters. The effect of 'practices' employed by nurses at this clinic suggest a disciplinary 'presence' particularly where the nurse is physically absent.

When it is addressed at all in the nursing literature, power is largely taken as something which nurses 'lack'. Benner (1984) attempts to redress the issue of power, rightly, by turning her gaze towards practice. However, once there she privileges the nurses voice above all others, reproducing existing accounts of what nurses take to be their position in the 'hierarchy': powerlessness. It must be remembered that Benner, in common with the nurses at Hillcrest, constitutes that hierarchy in interaction with clients and physicians. Benner's position then, fails to come to grips with the implications of power as something which is exercised *through* contextualized action. How practices are enacted within particular contexts is now examined.

Despite claims that much of their practice takes place beyond the physical boundaries of the clinic, in practice, moving away from the clinic presented nurses at Hillcrest with difficulties. Significantly, from a health promotion perspective, shifting work locales to the clinic offers clients a greater possibility for refusing the service. No longer 'faced' with having to turn the nurse away at the door, a difficult prospect at best, parents may now simply choose not to attend the clinic. Instances of failure to attend might be anticipated to be minimal in a highly 'disciplined' society and, as was the case at Hillcrest, did not constitute a problem. Instead, a greater concern uncovered through the readings made of practice is that, by nurses preferring their work to be accomplished in the clinic, opportunities for follow-up in the home are being missed. For instance, in chapter nine [p. 260] the way in which nurse Helen constructs baby Kim's insufficient weight gain as a problem was examined in detail. I suggested that Helen used technical devices available at the clinic in order to represent Kim's weight as problematic. The solution for the 'constructed problem' was identified not through interrogation of mother Marcia but rather by Marcia making a selection from a 'menu' offered by Helen. The crucial point is that the solution emerged not from the life-world of the parent and child but from the life-world of the clinic. Problems as well as solutions are constructed by nurses through the

skilled deployment of conversation. However, the parent's part in this construction must not be overlooked.

'Counselling techniques' used by clinic nurses actively seek out particular aspects of parental knowledge, knowledge which is appropriated by the nurse in order to offer solutions to problems. These techniques exclude all aspects of the parent-child experience which cannot be represented through technical means at the clinic. The life-world of the parent is important to the extent that it facilitates the construction of problems and solutions. When I followed up with Marcia two weeks after the visit to the clinic, accounts for Kim's weight loss were readily available [p. 268], that is, would have been available to the nurse. Constrained by their image of work, this account was actively excluded when the problem was 'calculated' (cf. Latour, 1987) at the clinic. The nurse's position as 'author' of particular versions of children's bodies draws on parental accounts, that is, those accounts are enrolled by nurses during the encounter. The enrolment of parental accounts influences the parents propensity to translate instructions given. However, what the parent translates is that version of the child represented or calculated in the clinic. No other solution is available for the parent once enrolled into the nurses' representation. As Bauman has stated:

> The know-how as to what weapons to select, and the weapons themselves, I can obtain only from others -- from those who control the access to weapons and possess the knowledge of how to use them. Being alone makes me dependent on others. It opens me up to others, but in a particular way, leaving a profound imprint on the shape of ensuing sociality (Bauman, 1992a, p. 20).

The use of technical measurements for constructing children as 'same' enable nurses to make instructions from their position which, transformed through the technicality of measurements, means that 'they have been here before' (Law, 1986).

Nurses express their expertise through conversational strategies which give the appearance of cross-checking on 'normal development'. For instance, when a mother brings a four month old baby to the clinic, 'normal development' consists of listening for an account from the mother that the baby can "grab and roll" [p. 240]. Representing 'advanced' technical measurements of

'development', nurses conduct spot-check surveys of each four month old child who comes to the clinic. In this way the nurse claims to be 'screening' for delays in development but also, importantly, she is setting up representations of the child for the parent's translation. Parents are first enlisted to help with the measurements, and are later enrolled into instructions. Now the parent is dependent upon the nurse's representation of their child.

Examples in the transcripts illustrate the 'power' of the community nurse. But, as has been stressed in the thesis, this is not a power which is held by the nurse, as an individual authority. Ann's laughter in response to Helen's serious suggestion that action be taken with regard to the baby's disproportionate weight and height measurements underlines the dangers for the nurse in not preparing the ground for instruction [p. 206]. Power, as a construct in the clinic, does not emerge as something wielded unconditionally by the nurse. Rather, power is radiated as an *effect* from clinic actors. Power is exercised by nurses through 'practices' which *include* taking measurements of children's height, weight and head circumference but do not end there.

Measurements offer nurses a language to transform the child from a qualitative being, unique in every way, into a quantified entity. The child, as a quantified entity, stands as a facility to which the nurse, in her image of work, alone has access. Access therefore, can be understood as possible through particular representations made of the child by the nurse using her measurement tools. Representations of the child cross over into the language of the nurse through her 'showing by saying what she sees' (Foucault, 1963/1973, p. 196).

When parents 'save the graph', for instance when the possibility of "slight mis-measurements" came to light [p. 220], the nurse's access is underlined as something which is not only permitted by parents but is, indeed, solicited. Nurses can afford to admit that errors are made because parents are already enrolled. The exercise of power has had its effect: parents do the work of surveillance while nurses have only to 'instruct'. Exceptions from the 'norm' do not take away from the nurse's effect. Instead they add to the effect precisely because the parents have now 'picked up' possibilities inhering to the representation of the child facilitated by clinic features and take these possibilities

further. Further even than the nurse can know. Parents *extend* what the nurse sets up. This is a 'translational' power (Latour, 1986) -- its' exercise relies on particular conditions which subsequently 'order' action observed in the clinic. The conditions of possibility for the work accomplished by nurses at Hillcrest Clinic are such that parents are primed for the effects of a transformational power. The ordered nature of work emerging from the reading of activities made in this thesis suggests that nurses have tapped into these conditions, and, as a result, invest their work interests with viability.

The protection of children, a prime interest for nurses, is no longer something which nurses conduct through methods of visual surveillance. As the thesis illustrates, the effect of clinic visits on parents is to turn the responsibility for surveillance over to them. Surveillance is now conducted on a much more routine basis than that which would be possible were nurses to do routine visits to the home. The enactment of practice is highly 'economic' in this sense.

Nurses have not given up their positions as protectors of children, however. The thesis illustrates, crucially, the extent to which the particular enactment of practice conducted in the clinic has altered the *location* of nurses' work. Alert and responsive to conditions facilitating work already framing action in the social context of 'late modernity', nurses at Hillcrest have developed and honed skills of audit. These skills are employed at strategic points in encounters and represent the mechanism through which 'occasions for promotion' are generated.

Lacking a unified discourse for health promotion, a 'gaze' analogous to that of the medical profession (in all its variety), nurses enact practice by generating reports of conduct which can then be audited. These nurses are not extending the medical discourse by substituting one aspect and reinstating another, for instance, as has been done in 'geriatrics' where the medical gaze has been replaced with a social 'gaze'. Instead these practices add to that colonizing of the life-world begun by others, including, but not exclusive to, the medical profession. 'Health promotion' is highly 'contextualized' at Hillcrest: it is 'opportunistic', it relies on opportunities afforded through parental accounts.

This is not to say it is not effective. Indeed, as I have illustrated in the preceding chapters, instructions issued in the clinic may have quite lasting effects when translated by parents back into the life-world of the home. Nurses work hard and demonstrate considerable skill at preparing the ground for instruction. Listening to a mother's account and appropriating aspects of that account, they secure an effect when the parent, in turn, picks up and employs in the life-world of the family home.

Sustained conduct observed across encounters and even practice locales indicates the extent to which staff members are knowledgeable about their methods for 'going on' in work encounters framed by a particular arrangement of social conditions informing action in this clinic. The methods are productive for nurses but are not limited in their effects to the constitution of work space in the clinic. The thesis has illustrated 'practice' as a skilled, social accomplishment. But also, the thesis asserts a particular view on power and how it can be theorized in studies of nursing practice. Power, as it is exercised in this clinic capitalizes on the conditions of possibility within which these actors operate. The thesis clears a space for further investigations into how nurses conduct their work as skilled, social accomplishments in locales which may well be organized by quite different conditions. Exploration of these conditions can be expected to generate readings of practice which will illustrate how, as conditions change, nurses develop alternative strategies in order to construct changing, but viable, interests.

1.5 Moving on in the field

Picking up Cohen's (1992) point about writing the field provisionally, I can make no claim regarding the certainty of having captured the 'whole' of practice. Having entered the field, and now, with this reading of practice, being located *in* the field, there are implications regarding the 'burden of authorship'

(Geertz, 1988) which can be addressed, in particular with regard to the question "Where to now?"

To the extent that this question is raised, it is a question of enrolment. The expectation that something will alter as a result of this reading of nurses' practice presupposes other readers draw associations between their understandings of practice and that presented here. The question arising from *this* representation of practice is, "Who will be enrolled by what in this writing of the field?"

It would, of course, be impossible to predict the associations made by such readers. Given this, it may be most profitable to acknowledge some precautions regarding enrolment into this reading of practice. Perhaps foremost, it is important to sustain a critical attitude toward representations, including this particular representation of practice. That is to say, mechanical replication of this study would be inconsistent with such a critical perspective.

Instead, readers enrolled by what ever means into this representation of practice can be expected to order and extend the interpretations made here -- just as parents ordered and extended representations of their children made by nurses in the clinic. These interpretations will, importantly, be framed by each reader's life-world. Maintaining a critical attitude towards this representation of practice read and understood within each individual's own life-world, therefore, has the potential for critically reviewing this representation as well as bringing into critical relief, those aspects of the reader's life-world within which associations have been drawn. Undertaken from a perspective of critical reflection, this 'work' of ordering and extending readings of practice will be substantially facilitated by remaining sensitive to the specifics of conduct and by sustaining a critical perspective towards the field.

APPENDICES

APPENDIX A

Interview Schedule

The following unstructured, open-ended questions were designed to assist the research participant to provide an account of their experience of providing nursing care or receiving nursing care in the research setting. The questions are general and non-specific, designed to encourage the participant to talk about those aspects which are of greatest importance in their role of nurse or patient (Wilson, 1985). Each one of the questions will be probed by the researcher to elicit accounts of specific experiences the respondent has had.

1. Questions following daily observation period:

A. Patients

- What did you pick up from that talk with the nurse?
- What was particularly interesting in what she said?
- Have you talked with this nurse before?
- What sorts of things have you spoken about?
- Do you think she understood what you wanted to talk about?
- How could you tell?
- Did you ask to speak with the nurse today?

B. Nurses

- How would you describe your general approach to in that session?
- How did that approach work today?
- How did you determine that these approaches were assisting you to provide the care required for this client?
- How do you feel it went?
- What were you hoping to get across to the patient?

2. Final Interview

A. Patients

- What is your first recollection of an encounter with a nurse or hospital?
- How do you feel about that now?
- Can you say something about your own health and the health of your child right now?
- How has that changed since your visit to the clinic?
- Can you remember special events or experiences that were important to you in keeping well?
- How have these things changed over the years?
- Were there particular experiences where a member of your family or a close friend was involved?
- How do you feel about that now?
- What sorts of things do you do, say in an average week, that keep you healthy?

B. Nurses

- Can you give me some idea of places you've worked in?
- Since becoming a nurse, is there one position which stands out from the others? Why?
- Can you give me some idea of what goes on here?
- Can you describe the most usual sort of working day in this clinic?
- Do you sometimes feel that there might be other ways to do ____?
- Can you point me to some aspects of your work you have found irritating?
- Can you think of the moment that gave you most pleasure working here during the last year (six months)?
- Was there a moment when you experienced great disappointment?
- Are there aspects of your work here where you feel particularly able to promote the health of the patient you're assigned to?
- How do you feel about that?
- What things keep you from being able to promote patient health?

APPENDIX B

Transcript codes

Bold	Action or non-verbal communication
Wel-l-l-l	Drawn out word or phrase
actively	Emphasized word or phrase
(...)	Unable to transcribe
(may have done)	Guess at unclear utterance
and then I / / did you?	Over-lapping utterances
(6.5) Right, then.	Numbers in brackets indicate silence in seconds and tenths of seconds
[Helen]	Participant's name spoken. Placed in square brackets to maintain anonymity.
[...]	Section of transcribed interview not displayed

APPENDIX C

Transcript of nurse-client interaction

Following is an excerpt of one of the nurse-patient interactions. It demonstrates the use of transcription symbols used throughout the thesis.

The interaction took place in the waiting area of the clinic and one of the clinic rooms. Ann had brought her four month old baby, Ken, into the clinic for immunization. She also brought her two year old boy, Mark, with her. During the interaction the two year old interrupted frequently. Ann attempted to keep Mark busy with colouring and toys. Ann was dressed in navy blue pants and a matching blouse. Helen was dressed in a navy blue print dress with lace around the collar. Helen had weighed and measured the baby out in the waiting area prior to the formal interview. Helen sat behind the desk in a swivel chair. She turned her body to the right so she was facing Ann during the interaction. Ann sat in the chair beside the desk. She held Ken in her lap and attempted to get Mark to sit on the small chair beside her. He remained restless throughout the interaction. The interaction began at 0950 h and was complete at 1010 h (20 min.)

(out in the waiting area)

Helen had called Ann's name and asked her to undress her baby and then bring him over to the scales. Ann brought the child over to the scales with nothing on and set him on his back on the tray above the scale. Helen read the weight out loud. During the measuring process Helen was talking to the researcher about her attempts to make telephone contact over the past few days.

Helen: (...) So whether that was a mis-dial because then I phoned two more times after that ... fifteen - nine ... and uhm, no answer. Oh, yeah. Where's that woman?!

MEP: Was that that lady yesterday?

Helen: Mrs. [name]

MEP: At three-thirty. Yeah-h-h-h.

Helen: Hold a hand on either side 'cause when I straighten knees we're going to pull away.

Helen shows Ann where to place her hands on the baby's head so that Helen can measure the baby's length.

Helen: (5.0) OK, I think sixty-four which is close enough to ... write it here ... twenty-five and a quarter. How are you going to be young man?

Mark: Mommy?

Ann: Yes, [Mark]?

Mark: Mommy watch me.

Helen: And four months, I don't have to check him 'cause he's fine. You can do him up.

Ann: OK?

Helen tells Ann to dress the baby, leaving his right thigh exposed and that when she's done to come to room three. A few minutes later Ann, carrying the baby in her arms and with Mark following behind, arrives at the door to the clinic room.

Ann: OK are you going to come and sit with us or are you going to play on the chalkboard, [Mark]?

Mark: I'm going to come in here.

Ann: OK. You have to sit very, very quietly, OK? Can you do that? Can you sit right there? Very quietly. OK. Can you take your hand out of your pants?

Mark: Sure.

Ann: Thank you.

Helen: Hi, Mrs. [last name]? I'm [Helen], how are you?

Ann: I've met you before.

Helen: You have! /

Ann: / You probably don't remember.

Helen: Well, I'm trying to think /

Ann: / You were /

Helen: / what's your first name now?

Ann: It's [Ann].

Helen: Uhm, ... [Ann] ...

Ann: You were at my sister-in-law's ... doing a ... uhm, baby visit with her second one. [Debbie]?

Helen: Oh! OK. OK, because /

Ann: / yeah, and I'd come over just after the baby had been born.

Helen: OK, so see you've got the inside advantage here.

Ann: Yeah, right. You see far too many people!

Helen: Well, no, but I know [Linda] because of [Cheryl]?

Ann: Yes.

Helen: [Cheryl] worked with me down in Bowness /

Ann: / Oh, OK./

Helen: / before she went back for her teaching degree.

Ann: Right.

Helen: Oh!! **(both laugh)** So how's life at your house?

Ann: Good, really good.

Helen: Good. (2.0) So, where's your girl?

Ann: Oh, well. No luck! **(laughs)** No such luck. Fine by me. **(laughs)**

Helen: We've got to get [Cheryl] married off. Maybe she'll have a girl.

Ann: That's right. Well, [Linda] is expecting again you know. (2.0) Uhm ...

Helen: Really?

Ann: Yeah, she's, gosh, she's close to forty and well, [Colleen]'s six years old I think, six or seven and she's due in August, so ...

Helen: Good luck! **(both laugh)**

Ann: Takes a lot of nerve doesn't it? I couldn't do it when I was forty! **(laughs)**

Helen: (3.0) Now, be nice. I'm still considering a fifth and I'm ...

Ann: Are you? Yeah, but you've had a few more.

Helen: Yeah, well, it might be a girl you know.

Ann: Have you got four boys?

Helen nods and smiles.

Ann: Do you really?

Helen: So good luck on your third! **(laughs)**

Mark begins to pull at Ann's arm and talks to her, trying to get her attention. Ann looks down at him and talks to him.

Ann: Can you sit down for a minute? You know what? We're going to give him his shot in that leg, [Mark]. Yeah.

Helen: [Mark] do you know Mom and I are going to be talking for a minute. Do you want to do something?

Ann: Would you like to crayon? Would you like to do some crayoning? That would be nice, wouldn't it?

Helen reaches into her lower left-hand drawer and withdraws a white piece of paper with a picture drawn on it and a small plastic container with crayons in it. She hands these to the child.

Ann: There you go.

Helen: Do you know what? If you kneel down on the floor, you can put this here and you can use that /

Ann: / There you go! /

Helen: / as a table. And you colour while we talk, OK? Then it won't be so boring for you.

Helen sits back in her chair and looks back at Ann.

Helen: Alright then /

Ann: / No, I figure that if I keep having them, I keep having boys just like you so ... **(laughs)** I don't /

Helen: / you're no fun! /

Ann: / want a girl that bad! **(laughs)**

Helen: Oh, I do.

Helen has set a yellow, soft toy on the desk in front of the baby. As the baby reaches for it Helen states:

Helen: He says, "I like that chicken mother".

Ann: Ye-e-es.

Helen: OK. This young man ...

Ann: Uh hmm /

Helen: / is a big boy.

Ann: Uh hmm.

Helen: Here's his, now I've put it in just that shade over the four months /

Ann: / yeah /

Helen: / and he's *ju-u-st* below the ninetieth percentile for length /

Ann: / uh huh /

Helen: / so he's mo-o-oved up tremendously 'cause he was just above average /

Ann: / Yeah /

Helen: / And his weight is just a bit below seventy-fifth so actually you can see that calorie growth /

Ann: / Yeah /

Helen: / has gone length-wise and he needs to fatten up a little. Eat a little bit more. Slow down his activity, whatever.

Ann laughs.

Helen: Yeah, sometimes that length will parallel off while the other /

Ann: / [Mark] was always tall, he was always up in the ninety ...

Helen: Yeah, well, he's certainly not underweight.

Helen glances over to where the older child is playing beside Ann's chair.

Ann: No, he's not suffering at all.

Helen: Head circumference maintaining up there around the ninetieth so ... he's a good sized boy.

Ann: Yeah.

Helen: As far as bone growth, he's up there! **(laughs)**

Ann: I didn't think he had such a big head.

Helen: You just don't notice this aro-o-o-und the back!

Helen rubs the baby's head all around the back.

Ann: Yeah, it's round this way. **(both laugh)**

Helen: OK...

Mark stands up and talks to Ann.

Ann: Yeah.

Helen: Well, we'll tell you all about it just when we get ready to do it, OK?

Ann: Go colour the picture OK? **(whispers)**

Helen: He says, I gotta check this place out.

Helen smiles at older child then turns back to look at the papers spread out in front of her at the desk.

Helen: OK, Mother, feeding.

Ann: Uh hmm?

Helen: As of four months ...

Knock heard at the door. Helen keeps her head and eye contact on Ann.

Ann: Yeah, he's on formula.

Helen: OK. Moved down to formula.

Ann: Yeah.

Helen: (2.0) And no solids yet or yes?

Ann: Uh-h-h, just a /

Knock heard again at the door.

Ann: / li-i-i-ttle tiny bit. He's had a couple spoonfuls of pablum but that's about all.

Helen: OK. As of when?

Ann: Oh, the last week or two.

Helen: So he had made uh, four months by then.

Ann: Oh yeah.

Knocking heard again at the door. This time the door opens without an invitation to do so from either Helen or Ann. A female's head can be seen looking into the room. She looks toward Helen.

Helen: Yes!

Voice: Sorry, I think I left my purse down in the corner there.

Helen: Oh, dear! No, you can't have it back! /

Ann: / Was there any money in it?!

Everyone laughs. Ann lifts up the purse from beside her chair and hands it to the woman at the door. The woman takes the purse and closes the door again.

Mark: She leaved her purse.

Ann: Yeah, she left it here.

Helen: Gee, maybe somebody'll leave me a million some day. **(Ann laughs)** OK, two to four months ...

Ann: Uh hmm?

Helen: Was he ill at all /

Ann: / No. /

Helen: / and did he run into any problems with any antibiotics, needed antibiotics?

Ann shakes her head "no".

Helen: No? And no injuries and no back in hospital.

Ann: No. He uhm had a renal scan, uhm, at uh, /

Mark talks to mother.

Ann: / just over three months. He's got, he's got a ... can you colour please for a minute? Mommy has to talk. Uhm, he ... , when I was over due they did an ultrasound and they found that, they thought that he had only one kidney /

Helen: / Right /

Ann: / and uh ... so, they did an ultrasound when he was born, diagnosed it as one kidney, so he went in May third or the fourth or whatever for a renal scan. He's got a, uh small right kidney and it's functioning at just about ten /

Mark: / He has his rattle /

Ann: / percent. So they feel you know that it's just not really functioning much at all. So he had a renal scan at the (Children's).

Helen: But he didn't stay overnight?

Ann: No. No, /

Helen: / OK /

Ann: / he was just in and out.

Helen: (2.0) Did he have a cord defect? Did they mention anything with your cord, /

Ann: / No. /

Helen: / that there was only two vessels?

Ann: No, no. It was all three vessels. It was all normal.

Mark talking and playing with a toy on the edge of the desk during this section. Ann and Helen maintain eye contact.

Ann: Can you colour for me please? **(whispers)**

Helen: (4.0) It's just I remember I had a cord defect once /

Ann: / Is that right? /

Helen: / and he went for all the renal scans and everything /

Ann: / Yeah /

Helen: / and ultrasounds too because they felt there was a risk there of there only being one.

Ann: Yup. Well, there's ... you know, that was the first thing that they looked at but, no. Everything was normal and healthy. It was just because he was over due that they did the ultrasound /

Helen: / sound and then decided that he was /

Ann: / and that's when they picked it up. And then they thought that it was just a lar-r-rge left kidney but it turns out that he *does* have a small right one but it's just not functioning. (1.5) So ...

Helen: (1.5) So at least one good thing /

Ann: / At least you know./

Helen: / about being a boy, they get less urinary tract infections than girls do /

Ann: / That's right./

Helen: / so ...

Ann: *And* you know, I don't really have a problem with it, you know, as long as we *know*, you know, there's really no big deal with it. As long as he takes really good care of that one, down the road.

Helen: Yeah. Hm-m-m. OK, when did you wean?

Ann: Uh-h-h-h-h ... it was about three and a half months.

Helen: Uh hmmm.

Ann: I had to go out of town so... That was it! **(laughs)** He got cut off! What can I say! **(laughs)**

Helen: Happens a lot, (like that).

Ann: Yeah, right!

Helen: So what kind of milk are you over to?

Ann: Enfalac.

Helen: And how much of that does he take in any one day?

Ann: Oh, probably about, ... probably about forty ounces I would think.

Helen: OK.

Ann: About one can of concentrate ... just over one can of concentrate, so I think that's about forty ...

Helen: Yeah, 'cause I think it's thirty, thirty-two for a can.

Ann: Yeah.

Mark: Are you going to give that shot on that leg?

Ann: Can you sit down and be quiet for a minute?

Helen: And so the pablum has *just* started /

Ann: / Yeah /

Helen: / and you're talking rice.

Ann: Yeah.

Helen: OK. (2.5) And you were on tri-vi-sol but you've stopped that now that he's on the formula, right?

Ann: Uhm, I still give him some.

Helen: OK, remember it's all in your formula now.

Ann: Is it?

Helen: Everything's added /

Ann: / OK, so I don't need to /

Helen: / now, you can sit it on the back burner.

Ann: OK.

Helen: And have you picked up any fluoride drops?

Ann: Yup.

Helen: OK. (2.0) And ... no teeth popped yet?

Ann: No, they're coming. He's really startin' to ...

Helen: ... chew and all /

Ann: / chew. He likes my mother's chin. **(laughs)** He doesn't like mine but he sure likes hers! I don't know, my brother was like that, he had this ... She *does* have a protruding chin, it's just the right size! He just knaws ...

Helen: I've seen babies who do that all the time.

Ann: Yup, but he won't take mine. It's really interesting ...

Helen: Yours is just so round and full **(laughs)**

Ann: That's right! **(laughs)**

Helen: It makes her feel important! **(laughs)** How's his bowels with the change over from milk?

Ann: Fine. It's /

Helen: / no concern with that /

Ann: / about once every two days. It's been wonderful ... **(laughs)**

Helen: Compared to breast? Was that two or three times a day?

Ann: No, he wasn't. He was like, once every week?

Helen: That was even *more* wonderful! Come on!

Ann: Yeah, I know, I couldn't believe it. Because with him, everytime you put a bottle in his mouth you got **(makes expressive movement with her hands and sound like a baby having a bowel movement)**, so ...

Helen is now looking down at the forms in front of her.

Helen: **(laughs)** OK, the weight's seventy four... OK, developmentally will he ... ?

Ann: Oh, he's /

Helen: / What's he up to? Is he rolling?

Ann: Yup. He's rolling ... he clunks over a couple of times but he can't really get over himself.

Helen: OK.

Mark: What colour do you want me to colour this in? Yellow or red?

Helen writes on the form in front of her. Mark talking while he plays with toy on the desk. Ann leans over to talk quietly to him.

Ann: (3.0) Can you be quiet for a minute please?

Helen: And is he just trying to reach for more things now?

Ann: Yeah. He's getting really good. The last few weeks he's getting into grabbing at things.

Helen: (2.0) Is he pretty vocal? He's so /

Ann: / Yes /

Helen: / quiet.

Ann: He's a quiet baby, he's a *very* quiet but you know when he hoots or hollers ... **(laughs)**

Mark: ... yellow or red, yellow or red ...

Ann leans over to talk to Mark.

Ann: Red. Can you colour for me please? Remember what I said? That we'd go to the car wash afterward? But I need

you to be quiet right now, OK? Can you do that? Please? For Mommy? Here you go.

Mark: I already crayoned! **(screams)**

Ann: Can you crayon his head? 'Cause there's nothing on his head.

Ann watches Mark for a second then looks up at Helen again.

Ann: But no, he's just a quiet baby. Unlike the other one.

Helen: He makes up for it, eh? **(laughs)**

Ann: Oh, yeah, they're as different as night and day.

Helen: OK, I've got seven to eight hours at night. Any more or any less?

Ann: Same...

Helen: Same? Yeah?

Ann: Yeah, he goes down at ten and wakes up at, anywhere from six to eight. More than that, six ... Oh, eight to ten hours. **(laughs)** What can I say?

Helen: Plus his naps? Do you get at least one?

Ann: Uh, two usually. One short one and one long one.

Mark pulls at Ann's arm.

Helen: Keep him!

Ann: Do you want to go and do a picture on the chalkboard outside?

Mark: No.

Ann: Well then you have to sit here and wait.

Mark: I just want to go to the car wash right now.

Helen: But you know what? I'll just be a few more minutes OK?

Ann: Yeah. You be patient. I know it's not one of your stronger suits. **(both laugh)**

Helen: How did this guy do with his immunization last time?

Ann: Fine, no problems /

Helen: / No sky-high fever, no screaming /

Ann: / You wouldn't have even *known* that he had it /

Helen: / good.

Ann: So if you do good this time we'll uh ... **(laughs)**

Helen: OK, we'll see how it goes.

Ann: Yeah.

Helen: OK, has he been around any other children with measles, mumps, chicken pox, anything like that /

Ann: / No /

Helen: / in the last two three weeks? How about any fevers in the past two three nights?

Ann: No.

Helen: Any other shots, needles, injections of any kind /

Ann: / No /

Helen: / other than what he had here. OK. So I'm giving exactly the same, DPT, but I'll put it right leg and he still gets another dose of oral polio. And tylenol dose ... I like to say, give it within the hour /

Ann: / Yeah /

Helen: / after the shot, repeat it five or six after that, throw him in the bath tonight, let him compress that leg, let him (...) so he drops the temperature (...). OK, so, current weight ...

Mark talking to Ann.

Ann: Did someone crayon that chair?

Mark: Yes.

Ann: Heavens no.

Helen: ... seven kilo's so he's one point three dose.

Ann: OK.

Helen: (2.5) Five to six hour spacing.

Helen writes this in Ann's blue "passport book".

Helen: (1.0) Any questions that you wanted to ask me about that I haven't given you a chance to ... ?

Ann: I don't thing so, no. No, he's just ... he's a good little baby. I'm going to keep him.

Helen: OK!

Mark picks up the container of crayons, knocks it against the small chair and the crayons fall out of the container. Ann looks down.

Ann: Now we have something for you to do. You can pick the crayons up for Mommy. Can you crawl under the chair there and pick those crayons up? Put them back in the container? Please?

Helen: OK, I've put your tylenol dose in the very front. So if you forget you can just /

Ann: / Yeah /

Helen: / pull out, ... you've got it.

Baby sneezes.

Ann: Oh, sakes, bless you! You slimed me!

Helen opens the desk drawer on the right hand side of the desk then looks back to the left towards Ann and baby.

Helen: Look at those cheeks.

Ann: Yeah, I know. Isn't that wonderful? Nothing finer than a baby with big cheeks. **(laughs)** Is there?

Helen starts preparing the immunization. While she's doing this she looks over the forms in front of her at the desk. She points to one particular entry and asks:

Helen: So how do they say the name they've got there for you, [nurse attempts name]?

Ann: [client's pronunciation].

Helen: [nurse repeats name]. Where does you're mother come from that she came up with [name] !? **(laughs)**

Ann: Well, that's my maiden name.

Helen: (1.5) Oh, your *last* name!

Ann: Yeah. That's my last, my maiden /

Helen: / Well, they've got it listed as your *first* name.

Ann: Oh, you're kidding!

Helen: Oh, golly, no wonder I was having so much trouble with it.

Ann: It's [Ann]. **(client spells her first name)**

Mark: Mommy, when's he going to get his shot?

Ann: Right now.

Helen: [Ann]. Well I'll remember that.

Ann: Yeah, see /

Helen: / actually I was /

Ann: / we named him [Ken] and said that that was the closest I was going to have to having someone named after me. Actually we just about ended up with [name] but we didn't go that far.

Helen: (5.0) Well, I was by seventh street the other day (working) at the front, (thinking).

Ann: Actually we live just around the corner.

Helen: Oh, do you?

Ann: We're on twenty-fifth. We've got an infill over there.

Helen: (3.0) Oh-h-h, twenty-fifth Ave ...

Ann: Yeah and sixth street.

Helen: So, so you must be out of [community clinic A], though /

Ann: / Yeah /

Helen: / 'cause I haven't visited you, right?

Ann: Yeah.

Helen: I think I stop at twenty-fourth /

Ann: / Yeah /

Helen: / and that's why I wouldn't have seen you. Oh, well, that's too bad.

Ann: Well, you know I, I don't know why I came over here, you know, just 'cause it's easier to come over here /

Helen: / And we're better!

Ann: Yeah, well at the time [Cheryl] was working over here. And I know [Cheryl] ...

Helen: From ...? /

Ann: / My husband knows [Cheryl] from Toastmasters.

Helen: Oh, yeah.

Ann: And he knows [John] from the White Hatters and all sorts of things so ...

Helen: (2.0) You see and then they moved her last summer. She's over at [Westmount clinic] now.

Ann: Is she?

Helen: Yeah.

Ann: Oh, I wondered where she'd gone.

Helen: Yeah, well she didn't move because she wanted to.

Ann: Yeah, well I didn't come over here specifically because of ... you know. It's just as easy to come over here as it is ...

Helen: They're quite busy at [Westmount]

Ann: Are they?

Helen: Yeah. She's working four, five clinics a *week*.

Ann: Is she?

Helen: Yeah. She says she's bored. The only thing there is school and babies. There's no seniors you know there's not near the diversity that there is here.

Ann: Yeah.

Helen moves in her chair closer to Ann.

Helen: (3.0) OK, Mom, let's turn him sideways. Are you going to watch this?

Ann: Are you going to watch [Mark]?

Helen: He's going to cry a little so we need you to give him a love after?

Helen stands up and reaches to the far left hand corner of the desk to pick up a small bell. She hands this to Mark.

Helen: And can you dingle this bell after I've given him his shot, OK? Wait 'til after.

Ann: Yeah, we'll tell you.

Helen turns back to Ann and assists her to hold the child in preparation for the injection.

Helen: And you'll hold his leg *just* like that.

Ann: There he is. I know, it's going to be hard on Mommy, yeah.

Helen: And he says "ah, ah, ah,".

Ann: Oh, are you going to cry already? We haven't even started.

Helen: He doesn't like to be held down.

Helen injects the vaccine into Ken's right thigh.

Ann: There we go.

Ann rocks child and holds him close to her chest. Helen turns to Mark to tell him to ring the bell.

Helen: Can you ring the bell for us [Mark]?

Mark rings the bell.

Ann: What's that? That's the bell!

Ken cries. Helen and Ann talk to Mark about how the baby feels about the injection. Unable to transcribe.

Helen: Say, "Oh, I need a cuddle Mom."

Ann: Oh, it's OK. Do you want to give hime a hug [Mark]? Do you want to give him a hug? Can you tell him it'll be better soon?

Helen: He says, "Well, I'm feeling a little sorry for him".

Baby cries. Mark hands the bell back to Helen.

Helen: Thank you [Mark]. Say "I feel more the bigger I get."

Ann: Oh-h-h-h. Oh-h-h-h-h. Oh, I know! Were you comatose the last time? You didn't even cry or talk.

Mark: Now? Now?

Helen: Do you want to give him a hug now?

Ann: Yeah, that's it. Oh, yeah.

Baby continues to cry.

Helen: You give him a little love today too. Yeah, he'll need it.

Helen picks up a card from the desk in which she has written the immunization given today.

Helen: OK, there's your card, there's DPT, and two months from now, and he *just gets* DPT.

Mark talks to Ann.

Ann: OK, You give him a kiss.

Ken cries.

Mark: OK, let's go to the car wash.

Ann: Yeah, we'll go to the car wash.

Mark: Maybe the car wash will make him happy.

Ann: You think the car wash will make him happy! **(laughs)** I know who it will make happy!

Helen: **(laughs)** OK, you're all done. We'll see you two months from now.

Ann: Thanks. Do I need my ... ?

Helen: You need this?

Ann: Yes. I think I've got everything else.

Helen: And you've got your purse?

Ann: Yup.

(end of tape)

APPENDIX D

Clinic Record

NURSING ASSESSMENT OF INFANT

NAME: _____ (No Defects = ✓)

DATE OF BIRTH: _____ (See Notes = *For Follow-Up)

UNIVERSAL SELF CARE REQUISITS: Child

AIR		FOOD/WATER		SOLITUDE/SOCIAL INTERACTION	
Respirations		Breast/Formula _____			
Retractions		Amount/Frequency _____			
Chest Shape		Lips		Bonding	
Nasal Patency		Mucosa		Eye Contact	
		Gums		Holding	
		Skin Turgor		Consolibility	
		Wet Diapers			

NORMALCY

BACK		EXTREMITIES		REFLEXES		HEAD	
Spine		Symmetry		Moro		Symmetry	
Pilonidal Dimpling		Mobility		Grasp		Shape	
		Folds		Babinski		Neck	
		Muscle Tone				Fontanels A	
		Hands				Fontanels P	
		Feet					

EARS		EYES		ABDOMEN	
Shape		Eyelids		Symmetry	
Position		Epicanthic Folds		Umbilicus	
Discharge		Conjunctiva		Appearance	
Hearing		Sclera			
		Pupils			

ELIMINATION

FEMALE		MALE		SKIN	
Anus		Anus		Color	
Stools		Stools		Rashes	
Labia		Testes		Birthmark	
Discharge		Penis		Scalp	

HAZARDS	
Child Safety	
Immunization	

COMMENTS: _____

DEVELOPMENTAL SELF CARE REQUISITS: Mom

Pregnancy

Labor

Delivery

ELIMINATION		NORMALCY		HAZARDS	
Episiotomy/Incision		Mental Health		Rubella/Polio	✓
Lochia		Family Planning		Td	
Breasts		Support System		PASSPORT 1.	2.
Bowels					

ACTIVITY AND REST		FOOD AND WATER	
Post Partum Exercises		Nutrition	

COMMENTS: _____

PARENT'S CONCERN: _____

DATE OF HOME VISIT _____ SIGNATURE _____

DATE OF INFANT ASSESSMENT _____ SIGNATURE _____

N209 (87/01)

INFANT AND PRESCHOOL NURSING NOTES

NAME: _____ D.O.B.: _____

SEE NOTES*

Date						
Age						
Parent's Concern						
FOOD & WATER Milk Type (amount/frequency)						
Solids						
Vitamins/Fluoride						
Dental Health						
ELIMINATION Bowels/T.Training						
ACTIVITY & REST Growth						
Development						
Sleep						
SOLITUDE AND **SOCIAL INTERACTION** Parenting						
HAZARDS Safety						
IMMUNIZATION **(Prevention of Disease)** Fever/Reaction Control						
Reaction to Previous Immunization						
Fit to Immunize						
Immunization Given						
Comments						

SIGNATURE

NAME _____ PAGE _____

DATE	

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